Missouri Consolidated Health Care Plan
Responses to Vendor Questions
2025 Medical Claim Audit RFP
March 12, 2025

These responses are provided by MCHCP to questions received from potential bidders for the 2025 Medical Claim Audit RFP.

	General	Response
1	In Exhibit B-Scope of Work, Section B2.1.10 includes "Confirmation of processes in place for incurred claims beginning Jan. 1, 2025, that any pharmacy rebates earned are properly paid to MCHCP". Please clarify that this is referring to specialty drugs administered through medical.	As stated in MCHCP's contract with Anthem, "TPA shall return to MCHCP 100% of the rebates it receives directly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by TPA and covered under the medical benefit portion of the Plan(s) ("Medical Drug Rebates")."
2	On the second last bullet for Background Information on Page 2 of the Introduction/Instructions document, the RFP states that "claim audits for Anthem are conducted in Indianapolis, IN." We currently audit Anthem virtually. Is that an option for this audit?	Yes
3	In Exhibit B-Scope of Work, Section B2.5 mentions Anthem's Customer Audit Policy and Procedure Manual. Are you able to provide this manual to us?	The current contract with Anthem is being provided as a reference document and named "Attachment 1 - Anthem contract". The audit policy is Schedule G of the contract. Also be aware of any changes to the policy as noted in Section 4.2 of the contract.
4	Exhibit B-Scope of Work, Section B2.2 states "The contractor shall trace the claims sample to MCHCP's data warehouse to validate the timely submission of claims to the warehouse." Are there performance guarantees for this process? Please explain the process and who from MCHCP's team would provide the data?	Anthem is required to submit a monthly claim file to MCHCP's data warehouse contractor, Merative. There are performance guarantees related to this task included in the contract. MCHCP has staff available to extract data from the warehouse.
5	Has MCHCP hired a contractor to perform these services in the past, and if so, can you identify the contractor(s) and provide copies of any reports that were generated?	Yes. The most recent audit was conducted by PBMares LLP. The audit report has been provided as a reference document and named "Attachment 2 - Audit report". The report became final following approval by the MCHCP Board of Trustees.
6	If there has been a previous contractor, can you also share the amount of fees awarded?	$35,000
7	With respect to Exhibit B-Scope of Work, Section B2.1, please define the "adjudication procedures review questionnaire" and provide guidance as to your expectations with respect to a final report?	The questionnaire would be developed by the auditor and a summary of the questionnaire responses included in the final report, along with areas of concern.
8	With respect to Exhibit B-Scope of Work, Section B2.1.10, please confirm you are seeking a medical claims review and not a pharmacy claims review.	Confirmed.
9	With respect to Exhibit B-Scope of Work, Section B2.2, would you be willing to entertain a "comprehensive and objective review" that will review 100 percent of medical claims paid in addition to the random, stratified sample?	MCHCP is not requesting a review of all paid claims at this time.

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10	With respect to Exhibit B-Scope of Work, Section B2.2 and B2.3, please explain the difference between these two features of the proposed Scope of Work.	Section B2.2 requires a random sample of 210 claims to ensure the accuracy of the benefit payment. Section B2.3 is a targeted sample, following an electronic review of all claims to identify duplicate payments and other areas of concern.
11	With respect to Exhibit B-Scope of Work, Section B2.4, please confirm that the TPA (Anthem) does not have the right to choose the contractor awarded a contract pursuant to this RFP.	Per MCHCP's agreement with Anthem, MCHCP will choose the audit company as long as the audit company does not have a conflict of interest with Anthem.
12	With respect to Exhibit B-Scope of Work, Section B2.4, please confirm the contractor awarded a contract pursuant to this RFP will be solely accountable to MCHCP and not to the TPA (Anthem) or Anthem's "audit protocols".	As stated in Exhibit B-Scope of Work, Section B2.5, MCHCP's contract with Anthem includes "Anthem's Customer Audit Policy & Procedure Manual". Any discrepancies between the scope of the medical claims audit proposed by the contractor and Anthem must be brought to the attention of MCHCP for pursuit of resolution.
13	With respect to Exhibit B-Scope of Work, Section B2.5, please provide a copy of the ASO agreement between MCHCP and Anthem.	The current contract with Anthem has been provided as a reference document and named "Attachment 1 - Anthem contract"
14	With respect to Exhibit B-Scope of Work, Section B2.5, please share what discrepancies you might expect between the contractor Scope of Work and Anthem's manual.	MCHCP does not expect significant discrepancies between the scope of work and Anthem's audit manual.
15	Our understanding is Anthem no longer permits onsite audits. Can you confirm Anthem has approved an outside audit in this scenario?	MCHCP does not require an onsite audit and will permit a virtual audit.
16	Has the plan confirmed audit dates with Anthem in July that we should be aware of? Audits typically are planned months in advance and knowing the date would allow us to block the time accordingly.	Audit dates have not yet been confirmed.
17	We recommend a statistical stratified sample of 220 claims. Is MCHCP open to 220 statistical claim audit vs. 210 sample audit?	MCHCP will consider changing the sample size. Please include your rationale for altering the sample size in your response to Question 3.5 of the questionnaire.
18	Some administrators do not allow for more than 25 targeted claims along with the 220 statistical claim audit. Has the plan reviewed the Anthem ASO language to confirm a 40 targeted claim audit is allowable?	Anthem's audit policy allows for up to 50 focused/targeted claims, not to exceed the 250 overall limitation.
19	Are the specialty drugs dispensed under the medical plan through a specific vendor? If so, which vendor?	Any drugs dispensed through the medical plan are by a medical provider.
20	Regarding Exhibit B, Section B2.2.2, please confirm whether MCHCP will provide a data extract from the warehouse to facilitate tracing the claims electronically.	MCHCP has staff available to extract data from the warehouse.
21	Regarding Exhibit B, Section B2.2.3, are the invoices electronic (data format) or images, e.g. PDF format?	Invoices are electronic.
22	Regarding Exhibit B, Section B3.4, is the Board presentation virtual or in person?	MCHCP can accept a proposal for either a virtual presentation of an in-person presentation.

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23	Regarding Exhibit B, Section B1.1, is the January 1, 2024 – December 31, 2024 period for medical claims only?	Yes.
24	Regarding Exhibit B, Sections B1.1 and B2.1.10, is the January 1, 2025 – March 31, 2025 period for the pharmacy rebates only?	No. MCHCP is requesting a medical claim audit in addition to the pharmacy rebate audit for the January-March, 2025 time period.
25	Regarding Exhibit B, Section B2.1.10, are the pharmacy claims processed by Anthem? If not, who is the PBM?	The pharmacy rebate audit pertains only to claims processed by Anthem.
26	Regarding Exhibit B, Section B2.2.2, please clarify the reference to data warehouse.	Anthem is required to submit a monthly claim file to MCHCP's data warehouse contractor, Merative. MCHCP is requesting the auditor trace the sample claims to the data warehouse to validate timely submission of claims to the warehouse.
27	Regarding Exhibit B, Section B2.2.3, please clarify/confirm that the scope of work is to review invoices from Anthem to MCHCP regarding the claim paid amounts.	Confirmed.
28	Regarding Exhibit B, Section B2.2.3, do you prefer the contractor to complete the rebate review? Are you agnostic to the contractor using a subcontractor to perform the rebate review?	Subcontractors may be used to perform the rebate review, but must be identified in the proposal.

CONTRACT # 25-01012025-TPA BETWEEN
MISSOURI CONSOLIDATED HEALTH CARE PLAN
AND HEALTHY ALLIANCE LIFE INSURANCE COMPANY

This Contract is entered into by and between Missouri Consolidated Health Care Plan ("MCHCP") and Healthy Alliance Life Insurance Company dba Anthem Blue Cross and Blue Shield TPA, (hereinafter "TPA" or "TPA") for the express purpose of providing administrative services for MCHCP's self-funded employee benefit plans for State and Public Entity members, pursuant to MCHCP's 2025 Third Party Administrator RFP released February 7, 2024 (hereinafter "RFP").

1. GENERAL TERMS AND CONDITIONS

1.1 Term of Contract and Costs of Services: The term of this Contract is for a period of one (1) year from January 1, 2025, through December 31, 2025. This Contract may be renewed for four (4) additional one-year periods at the sole option of the MCHCP Board of Trustees. The submitted pricing arrangement for the first year (January 1 - December 31, 2025) is a firm, fixed price. The submitted prices for the subsequent (2^{nd} – 5^{th}) years of the contract period (January 1 - December 31, 2026, January 1 - December 31, 2027, January 1 – December 31, 2028, and January 1 – December 31, 2029, respectively) are subject to negotiation but shall not exceed the guaranteed maximum prices. Pricing for the one-year renewal periods is due to MCHCP by May 15 for the following year's renewal. All prices are subject to best and final offer which may result from subsequent negotiation.

1.2 Contract Documents: This Contract and following documents, attached hereto and herby incorporated herein by reference as if fully set forth herein, constitute the full and complete Contract and, in the event of conflict in terms of language among the documents, shall be given precedence in the following order:

a. Any future written and duly executed renewal proposals or amendments to this Contract;

b. This written Contract signed by the parties;

c. The following Exhibits listed in this subsection below and attached hereto, the substance of which are based on final completed exhibits or attachments required and submitted by TPA in response to the RFP, finalist negotiations, and implementation meetings:

   i. Schedule A- Pricing Pages
   ii. Schedule B – Base Services
   iii. Schedule C - Performance Guarantees
   iv. Schedule D – InterPlan Arrangements Schedule
   v. Schedule E – Business Associate Agreement
   vi. Schedule F – Information Security Schedule
   vii. Schedule G- Audit Policy

d. The original RFP, including any amendments, the mandatory terms of which are deemed accepted and confirmed by TPA as evidenced by TPA affirmative confirmations and representations required by and in accordance with the bidder response requirements described throughout the RFP.

Any exhibits or attachments voluntarily offered, proposed, or produced as evidence of TPA's ability and willingness to provide more or different services not required by the RFP that are not specifically described in this Section or otherwise not included elsewhere in the Contract documents are excluded from the terms of this Contract unless subsequently added by the parties in the form of a written and executed amendment to this Contract.

1.3 Integration: This Contract, in its final composite form, shall represent the entire agreement between the parties and shall supersede all prior negotiations, representations or agreements, either written or oral, between the parties relating to the subject matter hereof. This Contract between the parties shall be independent of and have no effect on any other contracts of either party.

1.4 Amendments to this Contract: This Contract shall be modified only by the written agreement of the parties. No alteration or variation in terms and conditions of the Contract shall be valid unless made in writing and signed by the parties. Every amendment shall specify the date on which its provisions shall be effective.

No agent, representative, employee or officer of either MCHCP or TPA has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with this Contract, which in any way can be deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No

negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of this Contract.

1.5 Drafting Conventions and Definitions: Whenever the following words and expressions appear in this Contract, any amendment thereto, or the RFP document, the definition or meaning described below shall apply:

- **"Amendment"** means a written, official modification to the RFP or to this Contract.
- **"May"** means permissible but not required.
- **"Must"** means that a certain feature, component, or action is a mandatory condition. Failure to provide or comply may result in a breach.
- **"Request for Proposal" or "RFP"** means the solicitation document issued by MCHCP to potential bidders for the purchase of services as described in the document. The definition includes Exhibits, Attachments, and Amendments thereto.
- **"Shall"** has the same meaning as the word must.
- **"Should"** means desirable but not mandatory.
- The terms **"include," "includes,"** and **"including"** are terms of inclusion, and where used in this Contract, are deemed to be followed by the words "without limitation".

1.6 Notices: Unless otherwise expressly provided otherwise, all notices, demands, requests, approvals, instructions, consents or other communications (collectively "notices") which may be required or desired to be given by either party to the other during the course of this contract shall be in writing and shall be made by personal delivery, by prepaid overnight delivery, by United States mail postage prepaid, or transmitted by email to an authorized employee of the other party or to any other persons as may be designated by written notice from one party to the other. Notices to MCHCP shall be addressed as follows: Missouri Consolidated Health Care Plan, ATTN: Executive Director, P.O. Box 104355, Jefferson City, MO 65110-4355. Notices to TPA shall be addressed as follows: TPA ATTN Stephanie Vojicic, President, 1831 Chestnut Street, St. Louis, Missouri 63103.

1.7 Headings: The article, section, paragraph, or exhibit headings or captions in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract. Such headings or captions do not define, describe, extend, or limit the scope or intent of this Contract.

1.8 Severability: If any provision of this Contract is determined by a court of competent jurisdiction to be invalid, unenforceable, or contrary to law, such determination shall not affect the legality or validity of any other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if it were never incorporated into this Contract, but all other provisions will remain in full force and effect.

1.9 Inducements: In making the award of this Contract, MCHCP relies on TPA's assurances of the following:

- TPA, including its subcontractors, has the skills, qualifications, expertise, financial resources and experience necessary to perform the services described in the RFP, TPA's proposal, and this Contract, in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities.
- TPA has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand MCHCP's current offerings and operating environment for the activities that are the subject of this Contract and the needs and requirements of MCHCP during the contract term.
- TPA has had the opportunity to review and fully understand MCHCP's stated objectives in entering into this Contract and, based upon such review and understanding, TPA currently has the capability to perform in accordance with the terms and conditions of this Contract.
- TPA has also reviewed and understands the risks associated with administering services as described in the RFP.

Accordingly, on the basis of the terms and conditions of this Contract, MCHCP desires to engage TPA to perform the services described in this Contract under the terms and conditions set forth in this Contract.

1.10 Industry Standards: If not otherwise provided, materials or work called for in this Contract shall be furnished and performed in accordance with best established practice and standards recognized by the contracted industry and comply with all codes and regulations which shall apply.

1.11 **Force Majeure:** Neither party will incur any liability to the other if its performance of any obligation under this Contract is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but aren't limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, and strikes other than by TPA's or its subcontractors' employees.

1.12 **Breach and Waiver:** Waiver or any breach of any Contract term or condition shall not be deemed a waiver of any prior or subsequent breach. No Contract term or condition shall be held to be waived, modified, or deleted except by a written instrument signed by the parties. If any Contract term or condition or application thereof to any person(s) or circumstances is held invalid, such invalidity shall not affect other terms, condition or application. To this end, the Contract terms and conditions are severable.

1.13 **Independent Contractor:** TPA represents itself to be an independent contractor offering such services to the general public and shall not represent itself or its employees to be an employee of MCHCP. Therefore, TPA hereby assumes all legal and financial responsibility for taxes, FICA, employee fringe benefits, worker's compensation, employee insurance, minimum wage requirements, overtime, etc. and agrees to indemnify, save, and hold MCHCP, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters. TPA assumes sole and full responsibility for its acts and the acts of its personnel.

1.14 **Relationship of the Parties:** MCHCP, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Contract constitutes a contract solely between MCHCP and TPA that TPA is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (BCBSA) permitting TPA to use the Blue Cross and Blue Shield Service Marks in Missouri, and that TPA is not contracting as the agent of BCBSA. This Contract does not create a partnership, franchise, joint venture, agency, or employment relationship between the parties.

1.15 **No Implied Authority:** The authority delegated to TPA by MCHCP is limited to the terms of this Contract. MCHCP is a statutorily created body corporate multi-employer group health plan and trust fund designated by the Missouri Legislature to administer health care services to eligible State of Missouri and public entity employees, and no other agency or entity may grant TPA any authority related to this Contract except as authorized in writing by MCHCP. TPA may not rely upon implied authority, and specifically is not delegated authority under this Contract to:

- Make public policy;
- Promulgate, amend, or disregard administrative regulations or program policy decisions made by MCHCP; and/or
- Unilaterally communicate or negotiate with any federal or state agency, the Missouri Legislature, or any MCHCP vendor on behalf of MCHCP regarding the services included within this Contract.

1.16 **Third Party Beneficiaries:** This Contract shall not be construed as providing an enforceable right to any third party.

1.17 **Injunction:** Should MCHCP be prevented or enjoined from proceeding with this Contract before or after contract execution by reason of any litigation or other reason beyond the control of MCHCP, TPA shall not be entitled to make or assess claim for damage by reason of said delay.

1.18 **Statutes:** Each and every provision of law and clause required by law to be inserted or applicable to the services provided in this Contract shall be deemed to be inserted herein and this Contract shall be read and enforced as though it were included herein. If through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then on the application of either party the Contract shall be amended to make such insertion or correction.

1.19 **Governing Law:** This Contract shall be governed by the laws of the State of Missouri and shall be deemed executed at Jefferson City, Cole County, Missouri. All contractual agreements shall be subject to, governed by, and construed according to the laws of the State of Missouri.

1.20 **Jurisdiction:** All legal proceedings arising hereunder shall be brought in the Circuit Court of Cole County in the State of Missouri.

1.21 **Acceptance:** No contract provision or use of items by MCHCP shall constitute acceptance or relieve TPA of liability in respect to any expressed or implied warranties.

1.22 Survival of Terms: Termination or expiration of this Contract for any reason will not release either party from any liabilities or obligations set forth in this Contract that: (i) the parties expressly agree will survive any such termination or expiration; or (ii) remain to be performed or by their nature would be intended to apply following any such termination or expiration.

2 TPA's Obligations

2.1 Security Deposit: TPA must furnish an original performance security deposit in the form of check, cash, bank draft, or irrevocable letter of credit, issued by a bank or financial institution authorized to do business in Missouri, to MCHCP within ten (10) days after award of the contract and prior to performance of service under the contract. The performance security deposit must be made payable to MCHCP in the amount of $5,000,000.00. The contract number and contract period must be specified on the performance security deposit. In the event MCHCP exercises an option to renew the contract for an additional period, TPA shall maintain the validity and enforcement of the security deposit for the renewal period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $5,000,000.00.

2.2 Electronic Transmission Protocols: TPA and all subcontractors shall maintain encryption standards of 2048 bits or greater for RSA key pairs, and 256 bit session key strength for the encryption of confidential information and transmission over public communication infrastructure. Batch transfers of files will be performed using SFTP or FTPS with similar standards and refined as needed to best accommodate provider configurations (i.e. port assignment, access control, etc.).

2.3 Subcontracting: Subject to the terms and conditions of this section, this Contract shall be binding upon the parties and their respective successors and assigns. Either Party may subcontract any of its duties under the Contract without the prior written consent of the other Party; however, the Party subcontracting the services shall remain responsible for fulfilling its obligations under this Contract. TPA further agrees to provide MCHCP with a list identifying all subcontractors who may perform part of the work to be performed under the Contract. In the event MCHCP has any concerns with any of the listed subcontractors or any other issue related to subcontracting under the Contract, TPA will meet with MCHCP to discuss its concerns and discuss mutually acceptable solutions.

2.4 Disclosure of Material Events: TPA agrees to immediately disclose any of the following to MCHCP to the extent allowed by law for publicly traded companies:

- Any material adverse change to the financial status or condition of TPA;
- Any merger, sale or other material change of ownership of TPA;
- Any conflict of interest or potential conflict of interest between TPA's engagement with MCHCP and the work, services or products that TPA is providing or proposes to provide to any current or prospective customer; and
- (1) Any material investigation of TPA by a federal or state agency or self-regulatory organization; (2) Any material complaint against TPA filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming TPA before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming TPA as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against TPA by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against TPA as a result of any material criminal or civil action in which TPA was a party; or (7) Any other matter material to the services rendered by TPA pursuant to this Contract.

  For the purposes of this paragraph, "material" means of a nature or of sufficient monetary value, or concerning a subject which a reasonable party in the position of and comparable to MCHCP would consider relevant and important in assessing the relationship and services contemplated by this Contract. It is further understood in that in fulfilling its ongoing responsibilities under this paragraph, TPA is obligated to make its best faith efforts to disclose only those relevant matters which to the attention of or should have been known by TPA's personnel involved in the engagement covered by this Contract and/or which come to the attention of or should have been known by any individual or office of TPA designated by TPA to monitor and report such matters.

  Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to terminate this Contract.

2.5 Off-shore Services: All services under this Contract shall be performed within the United States. TPA shall not perform, or permit subcontracting of services under this Contract, to any off-shore companies or locations outside of the United States. Any such actions shall result in TPA being in breach of this Contract.

2.6 Change in Laws: TPA agrees that any state and/or federal laws and applicable rules and regulations enacted during the terms of the contract which are deemed by MCHCP to necessitate a change in the contract shall be incorporated into the contract automatically. MCHCP will review any request for additional fees resulting from such changes and retains final authority to make any changes. A consultant may be utilized to determine the cost impact.

2.7 Compliance with Laws: TPA shall comply with all applicable federal and state laws and regulations and local ordinances in the performance of this Contract, including but not limited to the provisions listed below.

2.7.1 Non-discrimination, Sexual Harassment and Workplace Safety: TPA agrees to abide by all applicable federal, state and local laws, rules and regulations prohibiting discrimination in employment and controlling workplace safety. TPA shall establish and maintain a written sexual harassment policy and shall inform its employees of the policy. TPA shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subcontract so that such provisions will be binding upon each subcontractor. Any violations of applicable laws, rules and regulations may result in termination of the Contract.

2.7.2 Americans with Disabilities Act (ADA) and Americans with Disabilities Act Amendments Act of 2008 (ADAAA): Pursuant to federal regulations promulgated under the authority of The Americans with Disabilities Act (ADA) and **Americans with Disabilities Act Amendments Act of 2008 (ADAAA)**, TPA understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Contract or from activities provided for under this Contract on the basis of such disability. As a condition of accepting this Contract, TPA agrees to comply with all regulations promulgated under ADA or ADAAA which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

2.7.3 Patient Protection and Affordable Care Act (PPACA): If applicable, TPA shall comply with the Patient Protection and Affordable Care Act (PPACA) and all regulations promulgated under the authority of PPACA, including any future regulations promulgated under PPACA, which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

2.7.4 Health Insurance Portability and Accountability Act of 1996 (HIPAA): TPA shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations, as amended, including compliance with the Privacy, Security and Breach Notification regulations and the execution of a Business Associate Agreement with MCHCP.

2.7.5 Genetic Information Nondiscrimination Act of 2008: TPA shall comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) and implementing regulations, as amended.

2.7.6 Consolidated Appropriations Act of 2021 and No Surprises Act: TPA shall comply with the Consolidated Appropriations Act of 2021 (CAA) and the No Surprises Act (NSA) and implementing regulations, as amended.

2.7.7 Transparency in Coverage Rules: TPA shall comply with the Transparency rules, as amended.

2.8 Indemnification: TPA shall be responsible for and agrees to indemnify and hold harmless MCHCP from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against MCHCP as a result of TPA's, TPA's employees, or TPA's associate or any associate's or subcontractor's failure to comply with section 2.7 of this contract.

2.9 Prohibition of Gratuities: Neither TPA nor any person, firm or corporation employed by TPA in the performance of this Contract shall offer or give any gift, money or anything of value or any promise for future reward or compensation to any employee of MCHCP at any time.

2.10 Solicitation of Members: TPA shall not use the names, home addresses or any other information contained about members of MCHCP for the purpose of offering for sale any property or services which are not directly related to services negotiated in this RFP without the express written consent of MCHCP's Executive Director. Notwithstanding the foregoing, TPA may use publicly available information to offer to members of MCHCP becoming Medicare eligible recommendations on replacement products available to such members of MCHCP to the same extent TPA uses such information to offer Medicare products to the general public.

2.11 Insurance and Liability: TPA must maintain sufficient liability insurance, including but not limited to general liability, professional liability, and errors and omissions coverage, to protect MCHCP against any reasonably

foreseeable recoverable loss, damage or expense under this engagement. TPA shall provide proof of such insurance coverage upon request from MCHCP. MCHCP shall not be required to purchase any insurance against loss or damage to any personal property to which this Contract relates. TPA shall bear the risk of any loss or damage to any personal property in which TPA holds title.

2.12 Hold Harmless: TPA shall indemnify, defend and hold harmless MCHCP, and its directors, officers, employees, agents and affiliates, from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) that are recovered in actions brought by a third party asserting liability for TPA's or its subcontractor's gross negligence or willful misconduct in the performance of the obligations under this Agreement. The obligation to provide indemnification under this Contract shall be contingent upon MCHCP: (i) providing TPA with prompt written notice of any claim for which indemnification is sought; (ii) allowing TPA to control the defense and settlement of such claim; provided, however, that TPA agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restriction or obligation on MCHCP without MCHCP's prior written consent, which will not be unreasonably withheld; and (iii) cooperating fully with TPA in connection with such defense and settlement.

2.13 Assignment: TPA shall not assign, convey, encumber, or otherwise transfer its rights or duties under this Contract without prior written consent of MCHCP. This Contract may terminate in the event of any assignment, conveyance, encumbrance or other transfer by TPA made without prior written consent of MCHCP. Notwithstanding the foregoing, TPA may, with advance written notice to MCHCP, assign or otherwise transfer its rights and obligations hereunder, in whole or in part, to: (i) any affiliate of TPA; or (ii) any entity surviving a transaction involving the merger, acquisition, consolidation, or reorganization of TPA or in which all or substantially all of TPA's assets are sold. For the purposes of this Contract, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in TPA provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company. Any assignment consented to by MCHCP shall be evidenced by a written assignment agreement executed by TPA and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of this Contract and to assume the duties, obligations, and responsibilities being assigned. A change of name by TPA, following which TPA's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. TPA shall give MCHCP written notice of any such change of name.

2.14 Patent, Copyright, and Trademark Indemnity: TPA warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of this Contract which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to MCHCP under this Contract. TPA shall defend any suit or proceeding brought against MCHCP on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of this Contract. This is upon condition that MCHCP shall provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, MCHCP may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by MCHCP at TPA's written request, it shall be at TPA's expense, but the responsibility for such expense shall be only that within TPA's written authorization. TPA shall indemnify and hold MCHCP harmless from all damages, costs, and expenses, including attorney's fees that TPA or MCHCP may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of this Contract. If any of the products provided by TPA in such suit or proceeding are held to constitute infringement and the use is enjoined, TPA shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If TPA is unable to do any of the preceding, TPA agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of MCHCP, only those items of equipment or software which are held to be infringing, and to pay MCHCP: 1) any amounts paid by MCHCP towards the purchase of the product, less straight line depreciation; 2) any license fee paid by MCHCP for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee presenting the time remaining in any period of maintenance paid for. The obligations of TPA under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of TPA without its written consent.

Except as may be explicitly set forth in this Contract, nothing herein shall be construed as an implied license by a Party to use the other Party's name, trademarks, domain names or other intellectual property. Neither Party shall use the name, trademarks, domain names or any other name or mark of the other Party in any press release, printed form, advertisement or promotional materials or otherwise, without the prior written consent of the other Party. In addition, MCHCP has no license to use the Blue Cross and/or Blue Shield trademarks or derivative marks (the "Brands") and nothing in the Contract shall be deemed to grant a license to MCHCP to

use the Brands. Any reference to the Brands made by MCHCP in its own materials are subject to prior review and approval by TPA.

2.15 Compensation/Expenses: TPA shall be required to perform the specified services at the price(s) quoted in this Contract. All services shall be performed within the time period(s) specified in this Contract. TPA shall be compensated only for work performed to the satisfaction of MCHCP. TPA shall not be allowed or paid travel or per diem expenses except as specifically set forth in this Contract.

2.16 Contractor Expenses: TPA will pay and will be solely responsible for TPA's travel expenses and out-of-pocket expenses incurred in connection with providing the services. TPA will be responsible for payment of all expenses related to salaries, benefits, employment taxes, and insurance for its staff.

2.17 Tax Payments: TPA shall pay all taxes lawfully imposed on it with respect to any product or service delivered in accordance with this Contract. MCHCP is exempt from Missouri state sales or use taxes and federal excise taxes for direct purchases. MCHCP makes no representation as to the exemption from liability of any tax imposed by any governmental entity on TPA.

2.18 Conflicts of Interest: TPA shall not knowingly employ, during the period of this Contract or any extensions to it, any professional personnel who are also in the employ of the State of Missouri or MCHCP and who are providing services involving this Contract or services similar in nature to the scope of this Contract to the State of Missouri. Furthermore, TPA shall not knowingly employ, during the period of this Contract or any extensions to it, any employee of MCHCP who has participated in the making of this Contract until at least two years after his/her termination of employment with MCHCP

3 MCHCP'S OBLIGATIONS

3.1 Administrative Services: MCHCP shall provide the following administrative services to assist TPA

- Certification of eligibility;
- Enrollments (new, change and terminations) in an electronic format;
- Maintenance of individual eligibility and membership data;
- Payment of monies due TPA;

3.2 Eligibility: MCHCP members are those employees, retirees and their dependents who are eligible as defined by applicable state and federal laws, rules and regulations, including revision(s) to such. MCHCP is the sole source in determining member eligibility. Effective and termination dates of plan participants will be determined by MCHCP. TPA shall not regard a member as terminated until TPA receives an official termination notice from MCHCP. TPA will be notified of enrollment changes through the carrier enrollment eligibility file, by telephone or by written notification from MCHCP. TPA shall refer any and all questions received from members regarding eligibility or premiums to MCHCP. MCHCP will notify TPA of requests for retroactive terminations when first known., TPA reserves the right to limit the effective date of retroactive terminations to a date not earlier than 365 days prior to the date notice is received.

3.3 Payment: MCHCP shall promptly pay the amounts due the TPA according to Schedule A.

4 RECORDS RETENTION, ACCESS, AUDIT, AND FINANCIAL COMPLIANCE

4.1 Retention of Records: Unless MCHCP specifies in writing a shorter period of time, TPA agrees to preserve and make available all of its books, documents, papers, records and other evidence involving transactions related to this contract for a period of seven (7) years from the date of the expiration or termination of this contract. Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds seven (7) years. TPA agrees that authorized federal representatives, MCHCP personnel, and independent auditors acting on behalf of MCHCP and/or federal agencies shall have access to and the right to examine records during the contract period and during the seven (7) year post contract period. Delivery of and access to the records shall be at no cost to MCHCP.

4.2 Audit Rights:

4.2.1 General Audit Rights: MCHCP and its designated auditors shall have access to and the right to examine any and all pertinent books, documents, papers, files, or records of TPA involving any and all transactions related to the performance of this Contract. TPA shall furnish all information necessary for MCHCP to comply with all Missouri and/or federal laws and regulations. MCHCP shall bear the cost of any such audit or review and will choose the auditing company. MCHCP and TPA shall agree to reasonable times for TPA to make such records available for audit.

4.2.2 Claims Audit Rights:

a. At MCHCP's expense, MCHCP shall have the right to audit Claims during regular business hours and in accordance with TPA's audit policy, as attached as Schedule G. An auditor or consultant must execute TPA's confidentiality agreement pertaining to TPA's Proprietary Information and Confidential Information prior to conducting an audit to the extent that a confidentiality agreement is not already in place. MCHCP has the right to hire an independent audit firm of its choosing, so long as the audit firm does not have a conflict of interest with TPA and is not engaged on a contingency fee or other similar basis.

b. MCHCP may conduct a Claims Audit once each calendar year and the Claims Audit may only relate to Claims processed during the current year or immediately preceding calendar year (the "Audit Period") and neither MCHCP nor anyone acting on MCHCP's behalf, shall have a right to audit Claims processed prior to the Audit Period. The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit. While Claims Audits are limited to once per calendar year, other types of audits, for example, a clinical audit, can also be conducted in the same calendar year as a Claims Audit.

c. MCHCP shall provide to TPA copies of draft, interim and/or final audit reports after MCHCP has reviewed them. Any errors identified and/or amounts identified as owed to MCHCP as the result of the audit shall be subject to TPA's review and comment prior to initiating any recoveries of Paid Claims pursuant to Section 5.27.1 of this Agreement. MCHCP shall provide to TPA copies of draft, interim and/or final audit reports, after MCHCP has reviewed them. Any errors identified and/or amounts identified as owed to MCHCP as the result of the audit shall be subject to TPA's review and consent prior to initiating any recoveries of Paid Claims pursuant to Section 5.27.1 of this Agreement. TPA reserves the right to request termination of any audit being performed by or for MCHCP, if TPA determines that the confidentiality of its information is not properly being maintained or if TPA determines that MCHCP or auditor is not following TPA's audit policy. The audit shall be suspended while TPA and MCHCP come to a mutual agreement as to any action, including but not limited to, termination of the audit.

d. A Claims Audit is limited to 250 claims per calendar year. This limit will not apply if MCHCP and TPA mutually agree that the limit would not allow the sample size to be statistically sound. Further, any sample limits for other audit types set forth in Schedule G, will not apply if MCHCP and TPA mutually agree that the limit would not allow the sample size to be statistically sound.

e. A Claims Audit performed pursuant to this Agreement shall be the final Claims Audit for the Claims Audit Period and for any prior Claims Audit Period unless otherwise agreed to in writing by the Parties.

4.3 Ownership: Except as otherwise defined as TPA Proprietary Information, all data developed or accumulated on behalf of MCHCP by TPA under this Contract shall be owned by MCHCP. TPA may not release any MCHCP data without the written approval of MCHCP. MCHCP shall be entitled at no cost and in a timely manner to all data and written or recorded material pertaining to this Contract in a format acceptable to MCHCP. MCHCP shall have unrestricted authority to reproduce, distribute, and use any submitted report or data and any associated documentation that is designed or developed and delivered to MCHCP as part of the performance of this Contract.

4.4 Access to Records: Upon reasonable notice, TPA must provide, and cause its subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are directly pertinent to the performance of the services. Such access must be provided to MCHCP and, upon execution of a confidentiality agreement, to any independent auditor or consultant acting on behalf of MCHCP; and any other entity designated by MCHCP. TPA agrees to provide the access described wherever TPA maintains such books, records, and supporting documentation. Further, TPA agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, or other conveniences deemed reasonably necessary to fulfill the purposes described in this section. TPA shall require its subcontractors to provide comparable access and accommodations. MCHCP shall have the right, at reasonable times and at a site designated by MCHCP, to audit the books, documents and records of TPA to the extent that the books, documents and records relate to costs or pricing data for this Contract. TPA agrees to maintain records which will support the prices charged and costs incurred for performance of services performed under this Contract. Also, TPA must furnish all information necessary for MCHCP to comply with all state and/or federal regulations. To the extent described herein, TPA shall give full and free access to all records to MCHCP and/or their authorized representatives.

4.5 Financial Record Audit and Retention: TPA agrees to maintain, and require its subcontractors to maintain, supporting financial information and documents that are adequate to ensure the accuracy and validity of TPA's invoices. Such documents will be maintained and retained by TPA or its subcontractors for a period of ten (7) years after the date of submission of the final billing or until the resolution of all audit questions, whichever is longer. TPA agrees to timely repay any undisputed audit exceptions taken by MCHCP in any audit of this Contract.

4.6 Response/Compliance with Audit or Inspection Findings: TPA must take action to ensure its or its subcontractors' compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the services or any other deficiency contained in any audit, review, or inspection. This action will include TPA's delivery to MCHCP, for MCHCP's approval, a corrective action plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

4.7 Inspections: Upon notice from MCHCP, TPA will provide, and will cause its subcontractors to provide, such auditors and/or inspectors as MCHCP may from time to time designate, with access to TPA service locations, facilities, or installations. The access described in this section shall be for the purpose of performing audits or inspections of the Services and the business of MCHCP. TPA must provide as part of the services any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

5 Scope of Work

5.1 Administrative Services: TPA understands that in carrying out its mandate under the law, MCHCP is bound by various statutory, regulatory and fiduciary duties and responsibilities and TPA expressly agrees that it shall accept and abide by such duties and responsibilities when acting on behalf of MCHCP pursuant to this engagement. TPA shall provide administrative services and administer benefits for the members of MCHCP in accordance with the provisions and requirements of this contract on behalf of MCHCP. TPA must administer benefits and services as determined by MCHCP and as promulgated by rule in Title 22 of the Missouri Code of State Regulations. TPA is obligated to follow the performance standards as outline in Exhibit C. The administrative services include:

5.1.1 TPA administrative services that include, but is not limited to, account management, claim services, member services, broad national network access for medical services (inclusive of mental health and substance abuse services), telehealth services (inclusive of primary and urgent care, mental health and substance abuse services, physical therapy, and other services that may be optimized on a telehealth platform), care management (inclusive of utilization management and case management); coordination with MCHCP business associates; reporting; banking; and web and consumer tools. TPA shall perform coordination of benefits ("COB") with other payors, including Medicare. In processing claims, TPA shall utilize its medical policies, medical policy exception process, precertification and preauthorization policies and applicable claims timely filing limits unless otherwise promulgated by rule in Title 22 of the Missouri Code of State Regulations.

5.1.2 Administration of independent dispute resolution processes for non-Network Provider Claims (including non-network air ambulance Provider Claims) as set forth under the Consolidated Appropriations Act and the Missouri Unanticipated Out of Network Caw law, as applicable, and if listed in Schedule A for the fee set forth in Section 3.C of Schedule A. MCHCP agrees to promptly notify TPA if an independent dispute resolution request is received. Failure to promptly notify TPA may impact independent dispute resolution processes. Notwithstanding anything to the contrary in the Contract , MCHCP shall assume liability for payment of all fees and costs, including but not limited to arbitrator fees, charged to, or paid by TPA as part of InterPlan Arrangement Claim independent dispute resolution processes.

5.1.3 TPA shall provide reporting as indicated in Schedule B to assist with compliance under the Consolidated Appropriations Act.

5.2 Coordination with MCHCP Business Associates: TPA must coordinate, cooperate, and electronically exchange information with MCHCP's business associates as identified by MCHCP. Necessary information can include, but is not limited to, the deductible and out-of-pocket accumulators, participation in care management or claims. Frequency of electronically exchanged information can be daily.

5.3 Account Management: TPA shall establish and maintain throughout the term of the contract an account management team that will work directly with MCHCP staff. This team must include, but is not limited to, a designated account executive, a member service manager, medical director, a clinical contact, a person responsible for preparing the reports and a information technology system representative. Approval of the

account management team rests with MCHCP. The account executive and service representative(s) will deal directly with MCHCP's benefit administration staff. The account management team must:

5.3.1 Be able to devote the time needed to the account, including being available for telephone and on-site consultation with MCHCP.

5.3.2 Be extremely responsive.

5.3.3 Be comprised of individuals with specialized knowledge of TPA's networks, functions, claims and eligibility systems, system reporting capabilities, claims adjudication policies and procedures, administrative services, standard and banking arrangements, and relations with third parties.

5.3.4 Act on behalf of MCHCP in navigating through TPA's organization. The account management team must be able to effectively advance the interest of MCHCP through TPA's corporate structure.

5.3.5 TPA agrees to provide MCHCP with at least thirty (30) days advance notice of any material change to its account management and servicing methodology and at least ten (10) days advanced notice of a personnel change in the TPA's account management and servicing team.

5.3.6 TPA agrees to allow MCHCP to complete an annual formal performance evaluation of the assigned account management team.

5.4 Meetings: TPA agrees to meet with MCHCP staff and Board of Trustees as requested to discuss the status of the MCHCP account in terms of utilization patterns and costs, as well as propose new ideas that may benefit MCHCP and its members. TPA is expected to present actual MCHCP claims experience and offer suggestions as to ways the benefit could be modified to reduce costs or improve the health of MCHCP members. Suggestions must be modeled against actual MCHCP membership and claims experience to determine the financial impact as well as the number of members impacted. TPA must also present benchmark data by using TPA's entire book of business, a comparable client(s) to MCHCP, or some other comparable industry norm.

5.5 Networks: TPA must have in place a network(s) which will offer access to MCHCP members nationwide. TPA shall maintain network(s) that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay or unreasonable travel. TPA shall comply with state and federal requirements regarding network adequacy, including but not limited to, The No Surprises Act.

5.5.1 TPA shall annually provide, no later than January 15 of each year, a network adequacy analysis that details the sufficiency of the network as compared to the standards set forth in 20 CSR 400-7.095 Provider Network Adequacy Standards. If TPA utilizes more than one network, such analysis shall be prepared for each network it utilizes in fulfillment of the requirements herein. For any deficiencies identified as part of the analysis, TPA shall provide a plan for how members will access services in deficient access areas and a plan for bringing network adequacy into compliance.

5.5.2 TPA shall have a process for monitoring and ensuring on an ongoing basis the sufficiency of the networks to meet the health care needs of the enrolled members within reasonable geography and reasonable time. In January and July of each year, the TPA shall provide a network adequacy analysis including geographic access report to MCHCP. In addition to looking at the needs from an overall member population standpoint, TPA shall ensure the networks are able to address the needs of those with special needs including but not limited to, visually or hearing impaired, limited English proficiency, and low health literacy. TPA shall notify MCHCP within five business days if the networks' geographic access changes from what was proposed by TPA.

5.5.3 TPA shall require that network providers be responsible for obtaining all necessary pre-certifications and prior authorizations and holding the member harmless for failure to obtain necessary authorizations.

5.5.4 TPA shall provide MCHCP with a list of alternative provider arrangements that it has in place, (including but not limited to, accountable care organization, primary care case management, patient-centered medical home, or other value-based payment arrangement not specifically mentioned) that provide providers a risk-based payment arrangement whether upside, downside or both in recognition of achievement of specified benchmarks or goals as of the effective date of this Contract if such arrangements impact MCHCP members. Upon request, for each alternative provider arrangement, TPA shall provide the geographic location of each arrangement, the number of MCHCP members potentially impacted, the financial arrangement in such detail as to provide MCHCP with an understanding of its potential financial obligation as a self-insured plan and how each is monitored for effectiveness from both quality and financial aspects.

5.5.5 TPA shall obtain discounts and other reductions, including through secondary networks as much as is possible for non-network claims.

5.5.6 TPA shall ensure provider network management strategies shall include areas of focus on ensuring provider directory data is up-to-date and accurate as possible. TPA shall remove terminated providers from the directory at the time of termination of contract or when TPA becomes aware that a provider is no longer providing direct patient care. TPA shall provide a quarterly review of the accuracy of the provider directory. If MCHCP discovers that provider information contained at TPA's website is inaccurate, MCHCP will contact TPA immediately. Upon being notified by MCHCP of an inaccuracy in the provider directory, TPA will initiate the correction of inaccuracies within ten (10) days after TPA has verified such inaccuracies with Provider.

5.5.7 In alignment with the No Suprises Act, TPA shall require providers and health care facilities to promptly refund enrollees amounts paid in excess of network cost-sharing amounts with interest, if the enrollee inadvertently received non-network care due to inaccurate provider directory information or the provider billed the enrollee for an amount in excess of network cost-sharing amounts and the enrollee paid the bill.

5.6 Direct Provider Arrangements: Subject to Blue Cross Blue Shield Association approval, TPA shall have the ability to provide administrative services to support network or provider arrangements that MCHCP have directly contracted for outside the arrangement offered by TPA. MCHCP shall notify the TPA of such arrangements prior to implementation. Such administrative support may include, but not be limited to, claims processing in accordance with the underlying plan design, utilization management, and appeals processing.

5.7 Written Notification of Provider Leaving Network: TPA shall provide written notice to affected members when providers leave the network

5.7.1 For facility terminations or non-renewals, TPA must notify all subscribers residing within a 40-mile radius of the facility at least 31 days prior to the termination or non-renewal or as soon as possible after non-renewal.

5.7.2 For non-facility provider terminations or non-renewals, TPA must notify all members who received care from the provider within the last 90 days and from primary care providers within the last 365 days.

5.7.3 TPA shall provide continuation of care in accordance with The No Surprises Act, RSMo Chapter 354.612 and MCHCP regulations. Subject to provider approval, MCHCP reserves the right to expand continuation of care beyond regulatory requirements.

5.8 Member Service: TPA must provide a high quality and experienced member service department. TPA's member service representatives (MSRs) must be fully trained in the MCHCP benefits, plan designs and other options.

5.8.1 TPA shall maintain a toll-free telephone line to provide prompt access for members and providers to qualified MSRs. At a minimum, member service must be available between the hours of 8:00 a.m. and 8:00 p.m. central time (CT), Monday through Friday except for designated holidays.

5.8.2 Member calls to TPA must be recorded and retained for a minimum of five (5) years. If prior to the recording being purged, TPA is notified of litigation by MCHCP, call recordings must be provided to MCHCP upon request.

5.8.3 The member services department shall include access to member advocates who are trained to meet member health care and benefit needs. The member advocate must be trained to be proactive and work with members to improve their health, their understanding and usage of benefits and how to find and get care. Examples of advocacy, include but is not limited to helping members find health care providers and schedule appointments, resolve claims and benefit issues, navigating choices for care, access personalized care and services to meet specific needs, and to connect to care teams for chronic and complex conditions.

5.8.4 TPA shall refer any and all questions received from members regarding eligibility or premiums to MCHCP.

5.8.5 TPA generally receives Member telephone numbers from MCHCP through enrollment files or the online employer access portal. Telephone numbers are provided directly to MCHCP by Members with the understanding that TPA may contact them, and MCHCP does not obtain telephone numbers through a service or a third party. TPA may contact Members by telephone for clinical purposes, benefit related issues or to perform services under the Agreement. Telephone numbers may be updated periodically by Members, and TPA will honor do not call requests. With regard to TPA's use of Member telephone numbers, MCHCP agrees to retain Member enrollment records for a period of at

least 4 years or as otherwise set forth in law and, upon request, will provide such records to TPA in a timely manner.

5.9 Identification Cards: TPA shall issue identification cards to Subscribers and/or Members, as applicable, and the content and design of the identification cards shall comply with applicable state and federal laws and BCBSA requirements. TPA is responsible for developing, printing and mailing identification cards directly to the member's home, as well as making them available digitally to the members. TPA is responsible for all associated production and mailing costs, as included in the base administration fee. Cards must be available to be mailed upon request of the member. Cards may be mailed to a larger group of members, or subset of members with agreement by MCHCP and TPA

5.10 Preventive Care Initiative: TPA shall provide a quality of care Initiative focused on preventive care each year. The initiative must include a minimum quarterly communication created and mailed to members. Selection of topics, content, timing, distribution method and draft language will be developed in coordination with MCHCP.

5.11 Communications: MCHCP reserves the right to review and approve all written communications and marketing materials developed and used by TPA to communicate specifically with MCHCP members at any time during the contract period. This does not refer to such items as provider directories and plan-wide newsletters as long as they do not contain MCHCP specific information such as eligibility, enrollment, benefits, or rates which MCHCP must review. Notwithstanding the foregoing, nothing herein prohibits TPA from communicating directly with members in the regular course of providing services under the contract (e.g., responding to member inquiries, etc.).

5.12 Tools: TPA shall have a variety of tools and information sources for MCHCP members. This may include, but is not limited to, the following:

5.12.1 New member information;

5.12.2 Health price transparency tools that shall utilize network provider rate information and are at a provider level detail as well as in summary;

5.12.3 Member ability to view claim status;

5.12.4 Member information to track deductible, coinsurance and out-of-pocket maximum status;

5.12.5 Explanation of benefits; and

5.12.6 Ability to query and download up to twenty-four (24) months of claims data

5.13 Website: TPA must have an active, current website that is updated regularly. MCHCP members must be able to access this site to obtain current listings of active network providers, print ID card, review benefits and plan design, review explanation of benefits, check status of deductibles, maximums or limits, research specific medical conditions, access to price transparency tools in compliance with regulatory requirements, obtain a history of medical claims, map provider locations and other information.

5.13.1 If MCHCP discovers the provider information contained at TPA's website is inaccurate, MCHCP will contact TPA immediately. TPA must correct inaccuracies as soon as practicable after being notified by MCHCP.

5.13.2 TPA shall implement a Single Sign-On (SSO) solution, enabling seamless access to all websites and online applications via MCHCP's secure member portal and, if applicable, MCHCP's member app. The SSO solution must be compatible with prevalent protocols, including but not limited to, SAML2, OpenID and Oauth2, and must comply with recognized security standards. The parties acknowledge that the SSO solution between TPA and MCHCP is fully functional and operational as of the effective date of the Contract. With respect to any new SSO solution requested by MCHCP for a vendor or subcontractor, TPA shall operationalize the SSO solution within six (6) months of MCHCP's request.

5.14 Implementation: Prior to January 1 of each Plan year, TPA shall implement any eligibility, plan design and benefit changes as directed by MCHCP. In addition, a final implementation schedule must be agreed to by MCHCP and TPA within 30 days of the Board of Trustee approval of each upcoming plan year benefits and plan designs. TPA shall implement any eligibility, plan design and benefit changes as directed by MCHCP. Failure on MCHCP's part to complete, by the agreed upon dates, the MCHCP key dependent tasks associated with the implementation may necessitate changes to the implementation schedule. At a minimum, the schedule must include the following activities as necessary:

5.14.1 Testing of eligibility and other files to and from MCHCP, and/or its business associates;

5.14.2 Acceptable date for final eligibility and other files to and from MCHCP and any business associates;

5.14.3 ID card production and distribution;

5.14.4 Finalization of benefits, plan designs, and other key elements,

5.14.5 Testing of appropriate files to and from MCHCP business associate(s), if necessary; and

5.14.6 Testing of claim file to data warehouse vendor.

5.15 Readiness Review: At least forty-five (45) days prior to the January 1, 2025 effective date, MCHCP will have a readiness review/pre-implementation audit of TPA, including an on-site review of the TPA's facilities if MCHCP deems it necessary. TPA shall participate in all readiness review/pre-implementation audit activities conducted by MCHCP staff or its designee to ensure TPA's operational readiness. MCHCP or its designee will provide TPA with a summary of findings as well as areas requiring corrective action. TPA is responsible for all costs associated with this review/audit/corrective action, including travel expenses of the MCHCP review team or its designee.

5.16 Eligibility Files: TPA shall be able to accept all MCHCP eligibility information on a weekly basis utilizing the ASC X12N 834 (005010X095A1) transaction set. MCHCP will supply specific record set information in an electronic format and TPA must process such information within 24 hours of receipt. TPA must provide a dedicated technical contact that will provide support to MCHCP Information Technology Department for EDI issues. It is MCHCP's intent to send a transactional based (change only) eligibility file weekly and a periodic full eligibility reconciliation file.

5.16.1 TPA will further develop an out of sequence (ad hoc) methodology for updating records outside of the normal schedule.

5.16.2 MCHCP will provide a recommended data mapping for the 834 transaction set.

5.16.3 Within two business days after processing any eligibility related file, TPA will provide a report that lists any errors and exceptions that occurred during processing. The report will also provide record counts, error counts and list the records that had an error, along with an error message to indicate why it failed. A list of the conditions TPA audits will be provided to ensure the data MCHCP is sending will pass TPA's audit tests.

5.16.4 TPA shall provide access to view data on its system via a web-based "Employer Portal" to ensure MCHCP provided eligibility files are correctly updating TPA's system, and for MCHCP member support to verify individual specific information on demand.

5.16.5 TPA shall supply a data dictionary of the fields MCHCP is updating on their system and the allowed values for each field.

5.16.6 TPA shall provide MCHCP with a monthly file ("eligibility audit file") in a mutually agreed upon format of TPA's eligibility records for all MCHCP members. Such file shall be utilized by MCHCP to audit TPA's records. Such eligibility audit file shall be provided to MCHCP no later than the second Thursday of each month.

5.16.7 The required method for all file transfers is Secure FTP. No PGP is required but can be implemented upon mutual agreement. MCHCP will provide an account for TPA transfers at ftp.mchcp.org.

5.16.8 TPA must work with MCHCP to develop a schedule for testing of the eligibility test record set on electronic media. MCHCP requires that TPA accept and run an initial test record set no later than October 15, 2024. Results of the test must be provided to MCHCP by October 30, 2024. Final acceptance of all eligibility file formats and responses are expected no later than November 30, 2024.

5.16.9 TPA and all its subcontractors shall use strong encryption methods that adhere to recognized security standards, such as AES-256, RSA, or ECC, for all data in transit and at rest, including File Transfer Protocol or other use of the Internet.

5.17 Appeals: TPA shall have a timely and organized system for resolving members' appeals in compliance with state and federal regulations, as amended. The system shall include, but not be limited to, two (2) levels of internal appeals, adverse benefit notices that shall be compliant with federal regulations and issued within regulatory timeframes. TPA shall agree that MCHCP shall have the ability to review and approve all adverse benefit notice templates prior to their use. TPA shall fully cooperate with the external appeal contractor (currently MAXIMUS Federal Services). Should an appeal result from an error or omission by TPA, such as quoting a wrong benefit or failing to tell a member or provider that prior authorization is required, and benefits are paid or denied inappropriately, then TPA shall be responsible for sixty percent (60%) of the paid amount of the claims directly involved in or affected by such appeal up to a maximum of $10,000 per occurrence. TPA

shall have a designated contact person or persons to be available including after normal business hours to gather information necessary for external appeals including expedited appeals where information must be made available within the time specified by the external appeal contractor.

5.18 Clinical Management: TPA shall integrate and coordinate utilization management, case management, discharge planning, quality management and medical policy and technology assessment in order to utilize health care resources and achieve optimum patient outcome in the most cost-effective manner.

5.18.1 TPA shall prospectively and concurrently review the medical necessity, appropriate level of care and length of stay for scheduled hospital admissions, emergency hospital admissions, medical, surgical, mental health and other health care services.

5.18.2 TPA shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. TPA may develop its own clinical review criteria, or may purchase or license clinical review criteria from qualified vendors. TPA shall make available its clinical review criteria upon request. TPA is encouraged to publish its clinical review criteria on its website for full transparency.

5.18.3 TPA shall provide physician-to-physician communication. A licensed, clinical peer of the same medical specialty shall evaluate the clinical appropriateness of adverse determinations.

5.18.4 TPA shall obtain all information required to make a utilization review decision, including pertinent clinical information. TPA shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

5.18.5 Utilization management services will be conducted by licensed registered nurses and TPA shall have available for review on a daily basis board-certified specialists representing all appropriate specialties. The utilization management staff must consult with appropriate specialists and sub-specialists in conducting utilization review of hospital, physician, mental health services, and other outpatient services. All adverse determinations shall be evaluated by a board-certified clinical peer prior to issuance of the denial.

5.18.6 TPA's prior authorization process shall have a goal to reduce the administrative burden on health care professionals and their staff and include a program(s) for providers to qualify that recognizes providers who routinely adhere to evidence-based clinical guidelines. The program(s) shall include a process for providers to annually qualify for continued status. TPA shall educate providers on the prior authorization requirements including, but not limited to, the services needing a prior authorization, documentation requirements, attestation requirements, and peer-to-peer review procedures

5.18.7 TPA's prior authorization process shall include means to involve patients in the process so that their voices are also captured as part of the approval process and decisions and appeal rights are communicated timely and without delay.

5.18.8 TPA shall annually provide a report of all services requiring prior authorization and the justification for including the services on the list with an estimated financial impact for inclusion and any adverse impacts for including the service on the prior authorization list. TPA shall allow MCHCP to remove specific services from prior authorization requirements or to modify the terms under which a service is placed on a prior authorization list.

5.18.9 TPA shall provide a toll-free telephone number and adequate lines for plan members and providers to access the utilization management program.

5.18.10 TPA shall identify case management opportunities and provide case management services for members with specific health care needs which will assist patients and providers in the coordination of services across the continuum of health care services, optimizing health care outcomes and quality, while minimizing cost.

5.18.11 TPA hall have a mechanism to proactively identify and target for intensified case management those cases having the potential to incur large expenditures. The large case management program shall identify potential large cases before expenses mount; mobilize local health care resources to meet the patient's long-term care needs; and coordinate the individual health needs of patients through multiple levels of care and transition the patient through appropriate levels of care as recovery milestones are met.

5.18.12 TPA shall provide case managers who will be experienced, professional registered nurses, licensed clinical social workers, and counselors who work with patients and providers to coordinate all services

deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

5.18.13 TPA shall provide an intervention program for frequent users of emergency room services. The program must include, at a minimum, the following elements:

5.18.13.1 Monthly identification of members with five (5) or more emergency room visits in a 12-month rolling period including the date, location and diagnoses of the emergency room visits and whether any of the visits resulted in an inpatient admission.

5.18.13.2 Coordinate with MCHCP's pharmacy benefit manager (PBM) to obtain relevant pharmacy claims.

5.18.13.3 Perform a review of member claims to determine the appropriateness of the emergency room visits and whether the member would benefit from case management services.

5.18.13.4 A physician reviewer shall review any case initially determined not to benefit from case management services for a final determination.

5.18.13.5 Once identified for case management, member outreach efforts must include, at a minimum, one (1) introductory letter, two (2) outbound phone calls and one (1) unable to contact letter.

5.18.13.6 Once the member accepts case management, the case manager shall perform an initial assessment and review the member's history and concerns and provide a plan of care and provide ongoing case management services as necessary.

5.18.13.7 TPA shall provide quarterly reports to MCHCP which include the number of members meeting criteria, number of members engaged in the program and the outcome of the frequent emergency room user member's engagement.

5.18.13.8 TPA shall coordinate with the MCHCP's PBM and provide necessary case management services as part of MCHCP's Pharmacy Lock-In Program.

5.19 Claim Payments Processing: TPA shall process all claims with incurred dates of service beginning with the contract effective date through December 31, 2025, and each subsequent year of this agreement in accordance with MCHCP regulations. TPA shall provide a dedicated, experienced claims processing team that will be permanently assigned to the MCHCP account.

5.19.1 TPA shall process claims utilizing the contracted discount arrangements negotiated with participating providers.

5.19.2 TPA shall process claims from non-network providers utilizing secondary network discounts where available. Where secondary network discounts are not available, TPA shall negotiate with the provider when the claim amount is over an established dollar threshold and, if no agreement reached, follow the established method as set forth in MCHCP regulations.

5.19.3 Any associated TPA fees for non-network fees shall be in accordance with the RFP and any calculations to arrive at the associated fees shall be disclosed to MCHCP in detail.

5.19.4 TPA shall, at a minimum, auto-adjudicate seventy-five percent (75%) of claims.

5.19.5 TPA shall pay 90% of all clean claims within times frames specified in Chapter 376.383 of the Revised Statutes of Missouri (see Exhibit C, Performance Guarantees for definition and penalty).

5.19.6 "Clean claim" shall have the same meaning as specified in Chapter 376.383 of the Revised Statutes of Missouri.

5.19.7 TPA shall maintain 97% payment accuracy in regard to their claims processing (see Exhibit C for definition and penalty).

5.19.8 TPA shall maintain 99% financial accuracy in regard to their claims processing (see Exhibit C, for definition and penalty).

5.19.9 If any payment results from an error or omission by TPA, such as benefit not programmed correctly, quoting a wrong benefit or failing to tell a member or provider that prior authorization is required, and benefits are paid inappropriately, then TPA shall be responsible for sixty percent (60%) of the paid amount of the claims directly involved in or affected by such error.

5.19.10 TPA shall have an automated process for tracking and resolving incomplete or pended claims. TPA shall proactively attempt to resolve issues with claims requiring additional information for proper adjudication, including member eligibility, referral, authorization, coordination of benefits, or workers' compensation information.

5.19.11 TPA shall have the capability to process both electronic and paper claims and provide a controlled process to provide electronic and manual payments and explanation of benefits (EOBs). Clear processes must be in place to handle payment reconciliation and correction accounting.

5.19.12 Overpayments made by TPA to providers shall be electronically adjudicated against future payments to same provider to ensure timely repayment to MCHCP. TPA shall notify the provider of the overpayment amount and that the overpayment will be offset against future payments until paid in full or the provider must remit the overpayment amount to TPA for the full amount should the provider not have sufficient future payments to refund the overpayment within ninety (90) days. If the provider fails to refund the entire amount after ninety (90) days, TPA shall continue to bill the provider for the amount owed and offset against future payments until the amount is paid in full. Overpayment recovery service collections that were not collected by an offset of a provider payment shall be remitted to MCHCP within thirty (30) days of receipt. TPA shall provide MCHCP supporting documentation of the overpayment amounts and associated collections whether by offset or by provider remittance.

5.19.13 TPA's claim system must have processes and edits in place to identify improper provider billing. This includes, but is not limited to, upcoding, unbundling of services, "diagnosis creep", and duplicate bill submissions.

5.19.14 TPA shall agree that if a claims payment platform change occurs throughout the course of the contract, MCHCP reserves the right to delay implementation of the new system for MCHCP members until a commitment can be made by TPA that transition will be without significant issues. This may include requiring TPA to put substantial fees at risk and/or agree to an implementation audit related to these services to ensure a smooth transition.

5.19.15 MCHCP acknowledges and directs TPA to utilize offsetting and cross-plan offsetting to recover overpaid Claims from Network Providers. Offsetting and cross-plan offsetting will be conducted only in cooperation with non-Network Providers who have expressly agreed to such procedures and have agreed that members will be held harmless. Offsetting is the practice of TPA recovering overpayments made to a Network Provider by withholding overpaid amounts from subsequent payments to be made to the same Network Provider. Cross-plan offsetting is the practice of TPA recovering overpayments made to a Network Provider for one member by withholding the overpaid amount from subsequent payments to be made to the same Network Provider for another member, who receives benefits under a different group health plan for which TPA pays the Claims on behalf of a different employer.

5.19.16 All penalties assessed by law for failure to timely pay claims will be borne by TPA.

5.19.17 TPA shall coordinate benefits in accordance with MCHCP regulations.

5.19.18 After the contract terminates, TPA is required to continue processing run-out claims for two years at no additional cost to MCHCP. Following the run-out period, TPA must turn over to MCHCP any pending items such as outstanding claim issues, uncashed checks and other pending items.

5.20 Payment Innovation Programs. If a Provider or Vendor participates in any TPA payment innovation program, in which performance incentives, rewards or bonuses are paid based on the achievement of cost, quality, efficiency, or service standards or metrics adopted by TPA ("Payment Innovation Programs"), Paid Claims shall also include the amount of such payments to Providers or Vendors for these Payment Innovation Programs. Such payments may be charged to MCHCP on a per Claim, lump sum, per Subscriber, or per Member basis and shall be based on TPA's predetermined methodology for such Payment Innovation Program, as may be amended from time to time. The total monies charged in advance to fund a Payment Innovation Program shall be actuarially determined as the amount necessary to fund the expected payments attributable to the Payment Innovation Program. Prior to its implementation, TPA shall provide MCHCP with a description of the Payment Innovation Program, the methodology that will be utilized to charge the MCHCP, and any reconciliation process performed in connection with such program. Payments to Providers or Vendors under these Payment Innovation Programs shall not impact Member cost shares. MCHCP shall have the right to audit such determinations and payments as outlined in this contract. TPA shall notify MCHCP of all Payment Innovation Programs that it has in place by January 31, 2025 and for future arrangements, within 30 days of implementing such an arrangement and annually thereafter.

5.21 Direct Agreements: Should MCHCP have a direct agreement with an accountable care organization or other direct provider or network arrangement, TPA shall process claims and provide other necessary supportive services included in this contract and in accordance with such agreement.

5.22 Subrogation Services: TPA shall identify and pursue subrogation claims on behalf of MCHCP. Subrogation results whenever there is a Third Party who is liable or responsible (legally or voluntarily) to make payments in relation to an accident, illness, or injury. Subrogation seeks to recover any amount paid or payable by a Third Party through a settlement, judgment, mediation, arbitration, or other means in connection with an illness, injury, or other medical condition. TPA shall have authority to settle claims in the amount of $25,000 or less for less than one hundred percent. Claims above $25,000 must have MCHCP approval prior to settlement. Subrogation recoveries shall be remitted to MCHCP not more than (60) days of collection. TPA shall charge MCHCP a subrogation fee provided in Schedule A. Any subrogation recoveries shall be net of the subrogation fee. Subrogation fees will not be assessed on subrogation recoveries until they are received by TPA and credited to MCHCP.

5.23 Performance Standards: Performance standards are outlined on Exhibit C. TPA shall agree that any liquidated damages assessed by MCHCP shall be in addition to any other equitable remedies allowed by the contract or awarded by a court of law including injunctive relief. TPA shall agree that any liquidated damages assessed by MCHCP shall not be regarded as a waiver of any requirements contained in this contract or any provision therein, nor as a waiver by MCHCP of any other remedy available in law or in equity. TPA is required to utilize MCHCP's vendor manager product that allows the TPA to self-report compliance and non-compliance with performance guarantees. Unless otherwise specified, all performance guarantees are to be measured quarterly, reconciled quarterly and any applicable penalties paid annually. MCHCP reserves the right to audit performance standards for compliance.

5.24 Optional Administrative Services: For those optional administrative services TPA proposed to MCHCP as part of the RFP process and including in supplemental pricing, MCHCP will evaluate each proposed service individually and make an annual determination to elect such service according to the specifications provided as part of the RFP. Once elected, TPA and MCHCP shall negotiate any necessary final programmatic details to successfully implement the chosen optional administrative service and amend the contract to include such services.

5.24.1 Recovery and Prepayment Analysis Services: Pursuant to the provisions of this Section, TPA shall conduct recovery activities including review of paid claims processed under this Contract (including during any claims runout period) and audits of Provider and Vendor contracts. The purpose of these services Is to determine whether paid claims processed under this Contract have been paid accurately and identify recoveries that can be pursued. TPA shall not be obligated to retain outside counsel or other third parties if TPA's recovery efforts are not successful. If TPA makes a recovery as a result of the services described in this Section, then TPA shall receive a fee provided in Schedule A as compensation for its services and MCHCP will receive the remaining recovery amount. TPA shall also engage in various claims prepayment analysis activities. These activities analyze claims after services are rendered by a Provider or Vendor but prior to claims payment to determine whether the billing and Claims submission are accurate and are intended to prevent inaccurate payments from being made. If the amount charged to MCHCP as a paid claim is less than the amount that would have been charged to MCHCP absent the services described in this Section, then TPA shall be entitled to receive the fee provided on Schedule A as compensation for its services. This fee shall only be charged where the prepayment analysis activities relate to a specific claim(s). This fee shall not be charged when the overpayment occurred as a result of the TPA's own actions.

5.24.2 The Parties understand and agree that TPA will not pursue additional recovery opportunities on MCHCP's behalf, including commencing litigation, filing a proof of a claim in a class action settlement, opting out of or objecting to a proposed settlement and engaging in settlement negotiations. In exercising its authority pursuant to this Section, TPA shall determine which recoveries it will pursue or claims that it will review prior to payment, and in no event will TPA pursue a recovery if it reasonably believes that the cost of the collection is likely to exceed the recovery amount or if the recovery is prohibited by law or an agreement with a Provider or Vendor. TPA will not be liable for any amounts it does not successfully recover or prevent from being paid based on claims prepayment analysis activities. MCHCP further understands and agrees that TPA shall have authority to enter into a settlement or compromise on behalf of MCHCP and Plan regarding these recovery, subrogation and audit services, including, but not limited to, the right to reduce future reimbursement to Providers or Vendors in lieu of a lump sum settlement. TPA may have contracts with Network Providers or Vendors or there may be judgments, orders, settlements, applicable laws or regulations that limit, under certain

circumstances, TPA's right to make recoveries or engage in claims prepayment analysis activities. TPA may, but is not required to, readjudicate claims or adjust Members' cost share payments related to the recoveries made from a Provider or a Vendor where such readjudicatlon or adjustment would result in a net benefit to Members. TPA shall credit MCHCP net recovery amounts after deduction of fees and costs as set forth in this Section 5 not later than 150 days following the receipt of the total recovery amount. If TPA does not credit MCHCP within 150 days of its receipt of the total recovery amount, TPA shall pay MCHCP interest calculated at the Federal Reserve Funds Rate in effect at the time of the payment. Provider or Vendor. TPA will not be liable for any amounts it does not successfully recover or prevent from being paid based on claims prepayment analysis activities. MCHCP further understands and agrees that TPA shall have authority to enter into a settlement or compromise on behalf of MCHCP and Plan regarding these recovery, subrogation and audit services, including, but not limited to, the right to reduce future reimbursement to Providers or Vendors in lieu of a lump sum settlement. TPA may have contracts with Network Providers or Vendors or there may be judgments, orders, settlements, applicable laws or regulations that limit, under certain circumstances, TPA's right to make recoveries or engage in claims prepayment analysis activities. TPA may, but is not required to, readjudicate claims or adjust Members' cost share payments related to the recoveries made from a Provider or a Vendor where such readjudicatlon or adjustment would result in a net benefit to Members. TPA shall credit MCHCP net recovery amounts after deduction of fees and costs as set forth in this Section 5 not later than 150 days following the receipt of the total recovery amount. If TPA does not credit MCHCP within 150 days of its receipt of the total recovery amount, TPA shall pay MCHCP interest calculated at the Federal Reserve Funds Rate in effect at the time of the payment.

5.24.3 TPA offers various Health and Wellness services (e.g. Hinge Health, Lark, Livongo and Virta), which will be paid by MCHCP via a claim, and carry no administrative costs paid to Anthem. MCHCP shall elect which services it wishes to participate in prior to each plan year.

5.25 Minority/Woman Owned Business: TPA shall use its best efforts to maintain 3.5% of the total value of the contract in Minority Business Enterprise and 1% of the total value of the contract in Women Business Enterprise Participation through the use of qualified subcontractors, suppliers, joint ventures, or other arrangements. The services performed or the products provided by the MBE/WBEs must provide a commercially useful function related to the delivery of the contractually-required service or product in a manner that will constitute an added value to the contract and shall be performed or provided exclusive to the performance of the contract. If, at any time, TPA falls below the target percentages set forth herein due to the termination of relationships with one or more of its qualified subcontractors or suppliers, TPA will diligently work to restore compliance with the targets as soon as reasonably practicable.

6 REPORTING

6.1 Reporting Requirements: TPA agrees that all data required by MCHCP shall be confidential and will not be public information. TPA further agrees not to disclose this or similar information to any competing company, either directly or indirectly. MCHCP reserves the right to retain a third party contractor to receive claims-level data from TPA and store the data on MCHCP's behalf. This includes a full claim file including, but not limited to all financial, demographic and utilization fields. TPA agrees to cooperate with MCHCP's designated third party contractor, if applicable, in the fulfillment of TPA's duties under this contract, including the provision of data as specified without constraint on its use.

6.2 Claims Data Reporting: TPA shall provide claims, person-level utilization data to MCHCP and/or MCHCP's data vendor in a format specified by MCHCP with the understanding that the data shall be owned by MCHCP. TPA shall provide data in an electronic form and within a time frame specified by MCHCP. TPA shall place no restraints on use of the data provided MCHCP has in place procedures to protect the confidentiality of the data consistent with HIPAA requirements. This obligation continues for a period of two (2) years following contract termination at no additional cost to MCHCP.

6.3 Telephone Reports: TPA shall provide quarterly reports detailing customer service telephone answer time and abandonment. The reports shall be submitted to MCHCP quarterly and are due within 30 days of the end of the quarter reported.

6.4 High Utilization: TPA shall provide a monthly report of cases that have the potential to incur large expenditures (over $50,000). The report shall include the patient's name, diagnosis, prognosis, a brief clinical summary and the amount paid to date. The report is due monthly and is to be provided no later than the 15th of each month.

6.5 Standard Reports: TPA shall provide their standard reporting package on a timely basis. (specifics as to reporting package bid will be added after award)

6.6 At the request of MCHCP and at TPA's expense, TPA agrees to participate in an annual customer satisfaction survey, such as the current version of the National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plan Survey (CAHPS) or a similar survey tool identified by MCHCP, using the established guidelines. A third party must conduct any such survey.

6.7 Annual Reporting: TPA shall provide an annual report, at their expense, which details how MCHCP performs on HEDIS® measures as developed and maintained by the NCQA for each year. At a minimum, the items to be reported must include measures in the following domains of care: Effectiveness of Care, Access/Availability of Care, Utilization, Risk Adjusted Utilization, and Measures Collected Using Electronic Clinical Data Systems. The annual report shall define the measures and compare the MCHCP rate against the HEDIS® book of business rate and the national benchmark rate. The report shall be provided no later than July 15 of each year for the prior year's data.

6.8 Ad Hoc Reporting: At the request of MCHCP, TPA shall submit additional ad hoc reports on information and data readily available to TPA. Fair and equitable compensation will be negotiated with TPA.

6.9 Acceptance of Reports: MCHCP will determine the acceptability of all claim files and reports submitted based upon timeliness, format and content. If reports are not deemed to be acceptable or have not been submitted as requested, TPA will receive written notice to this effect and the applicable liquidated damages, as defined in Exhibit C, will be assessed.

6.10 Consultation on Legislation: TPA shall consult on federal and state legislation, judicial rulings and other changes in rules or statutes that may affect MCHCP as needed and provide potential impact including fiscal impact to MCHCP upon request. TPA must respond within the timeframe specified as requested.

7 CANCELLATION, TERMINATION OR EXPIRATION

7.1 MCHCP's rights Upon Termination or Expiration of Contract: If this Contract is terminated, MCHCP, in addition to any other rights provided under this Contract, may require TPA to transfer title and deliver to MCHCP in the manner and to the extent directed, any completed materials. MCHCP shall be obligated only for those services and materials rendered and accepted prior to termination. TPA shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP subject to any offset by MCHCP for actual damages. The rights and remedies of MCHCP provided for in this Contract shall not be exclusive and are in addition to any other rights and remedies provided by law.

7.2 Termination for Breach: If either Party fails to comply with any material duties and obligations under this Agreement other than payment of amounts due under this Agreement, the other Party shall have the right to: (1) terminate this Agreement by giving the non-compliant Party at least 60 days prior written notice of termination; or (2) upon written notice to the other Party, suspend performance of its obligations under this Agreement. MCHCP acknowledges and agrees that in the event it is the non-compliant Party, TPA shall have no liability to any Member. Either Party, at its option, may allow the non-compliant Party to cure a breach of this Agreement and, upon acceptance in writing by that Party that a breach is cured, this Agreement may be reinstated retroactive to the date of the breach or suspension of performance. Notwithstanding any other provision of this Agreement, a Party may seek injunctive or other equitable relief from a court of competent jurisdiction should there be any unauthorized use or disclosure of Proprietary Information or Confidential Information by the other Party.

7.3 Termination Right: Notwithstanding any other provisions, MCHCP reserves the right to terminate this Contract at the end of any month by giving thirty (30) days' notice, without penalty.

7.4 Termination by Mutual Agreement: The parties may mutually agree to terminate this Contract or any part of this Contract at any time. Such termination shall be in writing and shall be effective as of the date specified in such agreement.

7.5 Arbitration, Damages, Warranties: Notwithstanding any language to the contrary, no interpretation shall be allowed to find MCHCP has agreed to binding arbitration, or the payment of damages or penalties upon the occurrence of a contingency. Further, MCHCP shall not agree to pay attorney fees and late payment charges beyond those available under this Contract, and, if applicable, no provision will be given effect which attempts to exclude, modify, disclaim or otherwise attempt to limit implied warranties of merchantability and fitness for a particular purpose.

7.6 Rights and Remedies: If this Contract is terminated, MCHCP, in addition to any other rights provided for in this Contract, may require TPA to deliver to MCHCP in the manner and to the extent directed, any completed materials. In the event of termination, TPA shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP subject to any offset by MCHCP

for actual damages. The rights and remedies of MCHCP provided for in this Contract shall not be exclusive and are in addition to any other rights and remedies provided by law.

8. PROPRIETARY AND CONFIDENTIAL INFORMATION

8.1 Each Party retains ownership of its Proprietary Information and Confidential Information (collectively "Information") and neither conveys ownership rights in its Information nor acquires ownership rights in the other Party's Information by entering into this Agreement or performing its obligations hereunder. Nothing in this Agreement shall impair or limit a Party's right to use and disclose its Information for its own lawful business purposes. For purposes of this Contact, TPA's Proprietary Information is non-public, trade secret, commercially valuable, or competitively sensitive information, or other material and information relating to the products, business, or activities of TPA or a TPA affiliate, including but not limited to: (1) Information about TPA's Provider network strategy, Provider negotiated fees, Provider discounts, and Provider contract terms; (2) information about the systems, procedures, methodologies, and practices used by TPA and TPA Affiliates in performing their services such as underwriting, Claims processing, Claims payment, and health care management activities; and (3) combinations of data elements that could enable information of this kind to be derived or calculated. TPA's Confidential Information is information that TPA or a TPA affiliate is obligated by law or contract to protect, including but not limited to: (1) Social Security numbers; (2) Provider tax identification numbers (TINs); (3) National Provider Identification Numbers (NPIs); (4) Provider names, Provider addresses, and other identifying information about Providers; and (5) drug enforcement administration (DEA) numbers, pharmacy numbers, and other identifying information about pharmacies. MCHCP's confidential information is information that may be considered a closed record pursuant to Chapter 610, Revised Statutes of Missouri.

8.2 Each Party shall maintain the other Party's Information in strict confidence and shall institute commercially reasonable safeguards to protect it.

8.3 MCHCP shall use and disclose TPA's Information solely for the purpose of administering the Plan. MCHCP shall not without TPA's advance written consent, (1) use or disclose TPA's Information, or reports or summaries thereof, for any purpose, other than administering the Plan; (2) combine TPA's Information with other data to create or add to an aggregate database that will or could be made available to any third party; (3) combine TPA's Information provided for a particular purpose with TPA's Information provided for another purpose; or, (4) sell or disclose TPA's Information to any other person or entity except as expressly permitted herein. TPA agrees that certain aggregated data may be disclosed in public settings and may include aggregate totals of payments made for certain services provided to multiple members (e.g., MCHCP paid a total of $X for all services related to diabetes provided in 2020.

8.4 MCHCP may disclose the minimum amount of TPA's Information necessary to MCHCP's stop loss carriers, consultants, auditors, and other third parties engaged by MCHCP (each a "Plan Contractor")-provided that: (1) each such third party needs to know such Information in order to provide services to MCHCP; and (2) prior to such disclosure, each such third party shall enter into a confidentiality agreement (or an appropriate amendment to an existing one, as applicable) with TPA with respect to the planned disclosure.

8.5 Upon termination of this Agreement, each Party shall return or destroy the other Party's Information or retain the Information in accordance with its reasonable record retention policies and procedures; provided however that each Party shall continue to comply with the provisions of this Section for as long as it retains the other Party's Information.

8.6 This Agreement shall not be construed to restrict the use or disclosure of information that: (1) is public knowledge other than as a result of a breach of this Agreement; (2) is independently developed by a Party not in violation of this Agreement; (3) is made available to a Party by any person other than the other Party, provided the source of such information is not subject to any confidentiality obligations with respect to it; or, (4) is required to be disclosed pursuant to law, order, regulation or judicial or administrative process, but only to the extent of such required disclosures and after reasonable notice to the other Party; or is required to be disclosed to a Member.

THE UNDERSIGNED PERSONS REPRESENT AND WARRANT THAT WE ARE LEGALLY FREE TO ENTER THIS AGREEMENT, OUR EXECUTION OF THIS AGREEMENT HAS BEEN DULY AUTHORIZED, AND OUR SIGNATURES BELOW SIGNIFY OUR CONSENT TO BE BOUND TO THE FOREGOING TERMS AND CONDITIONS.

Missouri Consolidated Health Care Plan

By: Judith Moore

Title: Executive Director

Date: 10/01/2024

TPA

By: Stephanie Vozici

Title: President

Date: 9/27/24

SCHEDULE A
TO
CONTRACT # 25-01012025-TPA

This Schedule A shall govern the Contract period from January 1, 2025 through December 31, 2025. For purposes of this Contract period, this Schedule shall supplement and amend the Contract between the Parties. If there are any inconsistencies between the terms of the Contract including any prior Schedules, and this Schedule A, the terms of this Schedule A shall control.

Section 1. Effective Date and Renewal Notice

Per Section 1.1 of the contract 25-01012025

Section 2. Broker or Consultant Base Compensation

Not Applicable

Section 3. Administrative Services Fees

A. Base Administrative Services Fee

The per Subscriber per month (PSPM) fees below apply from 01/01/2025-12/31/2025, 01/01/2026-12/31/2026, 01/01/2027-12/31/2027, 01/01/2028-12/31/2028, and 01/01/2029-12/31/2029. The PSPM fees for 01/01/2026-12/31/2026, 01/01/2027-12/31/2027, 01/01/2028-12/31/2028, and 01/01/2029-12/31/2029 are conditioned upon renewal by MCHCP.

	01/01/2025-12/31/2025	01/01/2026-12/31/2026	01/01/2027-12/31/2027	01/01/2028-12/31/2028	01/01/2029-12/31/2029
Base Administrative Services Fee	$22.85	$22.85	$23.54	$24.25	$24.98

Total Base Administrative Services Fee for 2025 is **$22.85 per Subscriber per month**

Retroactivity.

Per section 3.2 of the contract 25-01012025

B. Health and Wellness Program Fees

The PSPM fees below apply from 01/01/2025-12/31/2025, 01/01/2026-12/31/2026, 01/01/2027-12/31/2027, 01/01/2028-12/31/2028,and 01/01/2029-12/31/2029. The PSPM fees for 01/01/2026-12/31/2026, 01/01/2027-12/31/2027, 01/01/2028-12/31/2028,and 01/01/2029-12/31/2029 are conditioned upon renewal by MCHCP.

	01/01/2025-12/31/2025	01/01/2026-12/31/2026	01/01/2027-12/31/2027	01/01/2028-12/31/2028	01/01/2029-12/31/2029
WinFertility	$0.72	$0.72	$0.74	$0.76	$0.78
Total Health Complete	$11.50	$11.50	$11.85	$12.20	$10.57
Smart Shopper	$0.71	$0.73	$0.73	$0.75	$0.75

C. Other Fees or Credits

Fee for Subrogation Services. The charge to MCHCP is 25% of gross subrogation recovery.

Fee for Overpayment Identification, Prevention, and Claims Prepayment Analysis Activities. The charge to MCHCP is 25% of (i) the amount recovered from review of Claims and membership data and audits of Provider and vendor activity to identify overpayments and (ii) the difference between the amount MCHCP would have been charged absent prevention or prepayment analysis activities and the amount that was charged to MCHCP following performance of prevention or prepayment analysis activities. This includes, but is not limited to, COB, Host Blue activities, contract compliance, and eligibility. The fee for Overpayment Identification, Prevention, and Claims Prepayment Analysis Activities will not exceed $25,000.00 per Claim.

Fee for Independent Claims Review: Included in the Base Administrative Fee.

Fees and Costs for Independent Dispute Resolution. Notwithstanding anything to the contrary in the Contract, MCHCP shall assume liability for payment of all fees and costs, including but not limited to arbitrator fees, charged to or paid by TPA as part of independent dispute resolution processes.

Enhanced Personal Health Care Fee. A fee shall be charged for TPA's oversight of Enhanced Personal Health Care with Providers or Vendors. Such fee shall be 25% of the per attributed Member per month amount charged to MCHCP for the Provider performance bonus portion of the Enhanced Personal Health Care program. These charges are included in Paid Claims on the invoice and may accumulate towards any stop loss policy amounts.

Medical Drug Rebates: TPA shall return to MCHCP 100% of the rebates it receives directly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by TPA and covered under the medical benefit portion of the Plan(s) ("Medical Drug Rebates").

Program Fee Cap: The amount collected and retained by Anthem through Non-Network Savings Fees is 40% of recovered savings with annual not to exceed cap of $2.85 PEPM (2025); $2.99 PEPM (2026); $3.14 PEPM (2027); $3.30 PEPM (2028); $3.46 PEPM (2029)). Anthem reserves the right to review and modify the cap amount if Employer enrollment changes by more than 15%, if Employer's Member to Subscriber ratio changes by more than 5%, if there are significant changes in Employer's geographic membership distribution, or if Plan benefits are modified.

Fee for Accumulation of Essential Health Benefits Cost Shares with Pharmacy Carve-out Vendor. TPA shall coordinate with the MCHCP's pharmacy carve-out vendor to accumulate cost shares for Essential Health Benefits, as defined under the Affordable Care Act, to the deductibles and out-of-pocket maximums. The charge to MCHCP is per Subscriber per month. The charge to the MCHCP is included in the Base Administrative Services Fee.

Fee for Pharmacy Carve-out. MCHCP has carved-out Prescription Drug management services. The charge to the MCHCP is included in the Base Administrative Services Fee.

Fee for Claims Data File Transfer from Pharmacy Carve-out Vendor to Support Quality and Cost of Care Management Program. TPA shall obtain pharmacy claims data from the pharmacy carve-out vendor for use in Care Management Programs, including Payment Innovation Programs to help manage quality and cost of care. The charge to the MCHCP is included in the Base Administrative Services Fee.

Plan Program Credit. TPA will provide a Plan Program Credit in the amount of $280,000.00. per year, beginning January 1, 2025, and continuing through 2029, for each year that the contract is renewed. The Plan Program Credit only applies to expenses that are incurred and credited from January 01, through December 31, of each year and, subject to TPA approval, may be applied towards any combination of the following:

- Plan Communications
- TPA health and wellness programs
- health and wellness initiative, promotion, and campaign expenses
- Claims Audit
- ad hoc reporting
- and data feeds

The Plan Program Credit does not apply towards third party health and wellness programs, personnel costs, consultant expenses and fees, commissions, travel, office equipment and supplies, cash incentives, and programming expenses. TPA may pay a third party directly for approved Plan Program Credit amounts upon written direction from MCHCP.

Fee for Electronic Data Feeds to an Outside Vendor. TPA shall provide, on an annual basis, up to 12 electronic data feeds to an outside vendor in TPA's standard format. The charge to MCHCP is $1,000.00 for each additional feed in a non-standard format and/or new TPA vendor

Offshore Services Restriction Fee: Included in the Base Administrative Services Fee

Section 4. Paid Claims, Billing Cycle and Payment Method

A. Paid Claims

Paid Claims are described in Article 8.6-Paid Claims Definition of the Agreement.

B. Billing Cycle

Weekly

TPA shall notify MCHCP of the amount due to TPA as a result of Claims processed and paid by TPA according to the billing cycle described above. The actual date of notification of Paid Claims and the Invoice Due Date will be determined according to TPA's regular business practices and systems capabilities.

C. Payment Method

ACH Demand Debit Reimbursement for Paid Claims. TPA will initiate an ACH demand debit transaction that will withdraw the amount due from a designated MCHCP bank account no later than the next business day following the Invoice Due Date, however, if the Invoice Due Date falls on either a banking holiday, a Saturday or a Sunday, the withdrawal shall be made on the following banking day.

Section 5. Administrative Services Fees Billing Cycle and Payment Method

A. Billing Cycle

Self-Bill. The monthly administrative services fees are dueon the 10th day of each month following the month of coverage.

B. Payment Method

ACH or Wire Transfer Reimbursement. MCHCP shall deposit the amount due in a designated TPA bank account by the Due Date. The deposit shall be made in accordance with any policies and regulations of the bank necessary to assure that the deposit is credited to TPA's account no later than the next business day.

Anthem shall have the right to audit appropriate MCHCP records to determine the accuracy of the monthly payment. Any discrepancies must be identified by Anthem within 90 days after receipt of the payment and such discrepancy must be submitted in writing to MCHCP. Failure to identify a discrepancy within the time frame stated shall be considered as acceptance of MCHCP's calculations and records.

Section 6. Claims Runout Services

A. Claims Runout Period

Medical:

Claims Runout Period shall be for the 24 months following the date of termination of this Agreement.

B. Claims Runout Administrative Services Fee

Medical:

The fee for Claims Runout Services is included in the Base Administrative Services Fees in Section 3(A) of this Schedule A. Fees in Sections 3(B), 3(C), and 7 of this Schedule A that (i) are associated with Claims processed or reviewed during the Claims Runout Period including without limitation subrogation fees, Claims prepayment analysis fees, recovery fees, discount share fees, network access fees; or (ii) apply to the Agreement Period but were not billed during the Agreement Period, will be billed and payable during the Claims Runout Period. Payment is due to TPA by the Invoice Due Date.

Section 7. Inter-Plan Arrangements

The following Inter-Plan Arrangement-related fees are included in the Base Administrative Services Fee: Access Fees paid to Host Blues, the Administrative Expense Allowance ("AEA") Fee, Central Financial Agency Fees, ITS Transaction Fees, Blue Cross Blue Shield Global Core® Program services Fees and any Negotiated Arrangement Fees.

Negotiated Arrangement Fees:

Any administrative and/or network access fees will not be greater than the comparable Access Fee and/or AEA that would be charged under the BlueCard Program (CFA and ITS will continue to apply). Continued participation in any Negotiated Arrangement generally requires meeting certain membership criteria in the Host Blue service area. If membership declines below those thresholds, Claims for Members in the applicable Host Blue service area may, at the direction of the Host Blue, revert to the standard Access Fee and AEA described above. If membership changes such that MCHCP may qualify for a Negotiated Arrangement in a state not listed below, TPA will attempt to negotiate an arrangement with that state during its semi-annual review process and implement the negotiated fees and such fees will be reflected in Section 7 of Schedule A for the next Agreement Period.

Arkansas, Florida, Illinois & Texas

Included in the Base Administrative Services Fee

SCHEDULE B
TO
CONTRACT #25-01012025-TPA

This Schedule B shall govern the Contract period from January 1, 2025 through December 31, 2025. For purposes of this Contract period, this Schedule B shall supplement and amend the Contract between the Parties. If there are any inconsistencies between the terms of the Contract including any prior Schedules and this Schedule B, the terms of this Schedule B shall control.

The following is a list of services that TPA will provide under this Contract for the Base Administrative Services Fee listed in Section 3(A) of Schedule A. These services will be furnished to MCHCP in a manner consistent with TPA's standard policies and procedures for self-funded plans.

TPA may also offer additional, optional services to MCHCP, and such services, whether or not purchased by MCHCP, are not included in the services set forth below in this Schedule B. By way of example and not limitation, TPA may offer certain optional programs that include utilization management activities. In such event, the services associated with those programs are not included in the services described below. Recovery services will only be pursued or performed for Claims associated with these programs or that would have been impacted by these programs if the programs are purchased by MCHCP. If MCHCP has purchased such services, those services and any additional fees are also listed in Schedule A.

SERVICES INCLUDED IN THE BASE ADMINISTRATIVE SERVICES FEE IN SECTION 3A OF SCHEDULE A

Management Services

TPA 's benefits and administration as described in this paragraph:

- TPA definitions, and exclusions
- TPA complaint and appeals process (One mandatory level of appeal, one voluntary level of appeal)
- Claims incurred and paid as provided in Schedule A, excluding activities related to Claim recovery set forth in Scheduel A, Section 3(c) Other fees and credits.
- Accumulation toward plan maximums beginning at zero on effective date
- TPA Claim forms
- ID card
- Explanation of Benefits (Non-customized)

• Acceptance of electronic submission of eligibility information in HIPAA-compliant format

• Preparation of Benefits Booklet (accessible via internet)

• Account reporting - standard data reports

• Standard billing and banking services

• Plan Design consultation

• MCHCP eServices

- Add and delete Members
- Download administrative forms
- View Member Benefits and request ID cards
- View eligibility
- View Claim status and detail

• Responsible Reporting Entity for the Plan

- Information for preparation of SBC

Claims and Customer Services

- Claims processing services
- Medicare crossover processing
- MCHCP customer service, standard business hours
- Member customer service, standard business hours
- 1099s prepared and delivered to Providers
- Residency-based assessments and/or surcharges and other legislative reporting requirements
- Member eServices
- Member identity theft and credit monitoring and identity repair

Care Management

- Health Care Management
  - Referrals
  - Utilization management
  - Case management
  - TPA Medical Policy
- SpecialOffers
- Member Digital Tools

Networks

- Network Access and Management
- Online Provider directory

Other Services Required by Federal Law not Otherwise Specified in the Contract (as of the applicable effective date)

For Claims that qualify as no surprises Claims, TPA shall calculate and apply the Member's cost share at the in-network benefit level using the qualifying payment amount. TPA shall post a disclosure of the patient protections against balance billing on www.anthem.com and shall include applicable language in Claim denial notices and explanations of benefits.

Anthem shall handle no surprises Claims disputes on MCHCP's behalf including, but not limited to, IDR process.

Prepare advanced explanations of benefits to Members after receiving a notice of scheduled services from a Provider

Provide cost transparency tool/self-service tool access

Provide for continuity of care administration for Provider termination from the network

Provide air ambulance Provider reporting

Provide aggregated reporting as required under Section 204 of the CAA for the services that TPA administers under the Contract. This reporting does not include the D1 Premium and Life Years Report.

TPA represents that it is administering its Provider agreements consistent with the requirements set forth in Section 201 of the CAA. TPA will provide a statement of compliance to MCHCP pertaining to Section 201 of the CAA on an annual basis.

Upon request, TPA will provide the non-quantitative treatment limitation analysis for the standard services that TPA provides under the Agreement. TPA will also provide reasonable assistance to MCHCP in the event of a regulatory audit for compliance with the Mental Health Parity and Addiction Equity Act.

Post machine readable files on a monthly basis for the services TPA administers for the Plan on www.anthemcom

SCHEDULE C
TO
CONTRACT # 25-01012025-TPA

This Schedule C provides certain guarantees pertaining to TPA's performance under the Contract between the Parties ("Performance Guarantees") and shall be effective for the period from January 1, 2025 through December 31, 2029 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Schedule C and made a part of this Schedule C. This Schedule shall supplement and amend the Contract between the Parties. If there are any inconsistencies between the terms of the Contract including any prior Schedules and this Schedule C, the terms of this Schedule C shall control. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Attachments to this Schedule C, the terms of the Attachments to this Schedule C shall control unless otherwise specified.

Section 1. General Conditions

A. The Performance Guarantees described in the Attachments to this Schedule C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:

1. Performance Category. The term Performance Category describes the general type of Performance Guarantee.

2. Reporting Period. The term Reporting Period refers to how often TPA will report on its performance under a Performance Guarantee.

3. Measurement Period. The term Measurement Period is the period of time under which TPA 's performance is measured, which may be the same as or differ from the period of time equal to the Performance Period.

4. Penalty Calculation. The term Penalty Calculation generally refers to how TPA 's payment will be calculated, in the event TPA does not meet the target(s) specified under the Performance Guarantee.

5. Amount at Risk. The term Amount at Risk means the amount TPA may pay if it fails to meet the target(s) specified under the Performance Guarantee.

B. TPA shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Schedule C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by TPA shall be based on TPA 's then current measurement and calculation methodology, which shall be available to MCHCP upon request.

C. If the Parties do not have an executed Contract, TPA shall have no obligation to make payment under these Performance Guarantees.

D. Unless otherwise specified in the Attachments to this Schedule C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by TPA or its Vendors.

E. If MCHCP terminates the Agreement between the Parties prior to the end of the Performance Period, or if the Agreement is terminated for non-payment, then MCHCP shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.

F. TPA reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Schedule C upon the occurrence, in TPA's determination, of:

1. a change to the Plan benefits or the administration of the Plan initiated by MCHCP that results in a substantial change in the services to be performed by TPA or the measurement of a Performance Guarantee;

2. an increase or decrease of 15% or more of the number of Members that were enrolled for coverage on the latter of the effective date or renewal date of this Agreement;

3. a change in law or regulation that materially impacts underwriting assumptions made at the time of offering such Performance Guarantees.

Should there be a change in occurrence as indicated above and these changes negatively impact TPA 's ability to meet the Performance Guarantees, upon prior notice to MCHCP, TPA shall have the right to modify the Performance Guarantees contained in the Attachments. .

Some Performance Guarantees measure and compare year to year performance. The term Baseline Period refers to the equivalent time period preceding the Measurement Period. TPA will require specified historical Claims and utilization data to establish the Baseline Period for the first year of a Performance Guarantee utilizing a Baseline Period.

G. As determined by TPA, Performance Guarantees may be measured using either aggregated data or MCHCP -specific Data. The term MCHCP -specific Data means the data associated with MCHCP's Plan that has not been aggregated with other employer data. Performance Guarantees will specify if MCHCP -specific Data shall be used for purposes of measuring performance under the Performance Guarantee.

H. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if the MCHCP participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.

I. All Performance Guarantees in which TPA will make outbound calls or will reach out through email or other means to members will exclude members who TPA cannot reach due to incorrect or invalid telephone numbers, including numbers where permission is required by law but not provided, or those members who have requested that TPA not contact them.

J. All Performance Guarantees may be revisited and may potentially be impacted due to a cause beyond the reasonable control of a Party such as a pandemic (an outbreak of disease that affects an exceptionally high proportion of members) being declared by the Centers for Disease Control or if a Force Majeure event (meaning an act of God, civil or military disruption, terrorism, fire, strike, flood, riot or war) occurs during the Measurement or Baseline Period that impacts a meaningful portion of the MCHCP population.

Section 2. Payment

A. If TPA fails to meet any of the obligations specifically described in a Performance Guarantee, TPA shall pay MCHCP the amount set forth in the Attachment described under the Performance Guarantee. Payment shall be in the form of a credit on MCHCP's invoice for Administrative Services Fees, which will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the foregoing, TPA 's obligation to make payment under the Performance Guarantees is conditioned upon MCHCP's timely performance of its obligations provided in the Agreement, in this Schedule C, and the Attachments, including providing TPA with the information or data required by TPA in the Attachments. TPA shall not be obligated to make payment under a Performance Guarantee if MCHCP or MCHCP's vendor's action or inaction adversely impacts TPA 's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, which expressly includes but is not limited to MCHCP or its vendor's failure to timely provide TPA with accurate and complete data or information in the form and format expressly required by TPA.

C. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the actual annual enrollment during the Measurement Period.

Section 3. Performance Guarantee Amounts at Risk

Amount at Risk

The total amount at risk for the below performance guarantees between TPA and MCHCP Missouri Consolidated Health Care Plan shall not exceed the following:

Operations Guarantees:

$2,000,000.00

Network Guarantees:

$1,000,000.00

Care Management Guarantees:

$550,000.00

25.000% of Identified Applicable fees

Confirmation of all applicable fees for the performance guarantees will be reflected in MCHCP's Schedule C.

Maximum Amount Payable

The maximum amount payable under all guarantees between TPA and MCHCP Missouri Consolidated Health Care Plan shall not exceed 25.0% of the Total Health Complete fees, plus $3,550,000.

ATTACHMENT 1
TO
SCHEDULE C

Performance Guarantees
Operations Performance Guarantees

This Attachment is made part of Schedule C and will be effective for the Performance Period of January 1, 2025 through December 31 2025. This Attachment is intended to supplement and amend the Contract between the Parties.

Operations Guarantees

Performance Category	Year 1	Year 2	Year 3	Year 4	Year 5
Renewal Implementation	$100,000	$100,000	$100,000	$100,000	$100,000
Renewal Implementation Survey	$50,000	$50,000	$50,000	$50,000	$50,000
Claims Timeliness (14 Calendar Days)	$100,000	$100,000	$100,000	$100,000	$100,000
Claims Financial Accuracy	$100,000	$100,000	$100,000	$100,000	$100,000
Claims Accuracy	$100,000	$100,000	$100,000	$100,000	$100,000
Open Enrollment ID Card Issuance	$50,000	$50,000	$50,000	$50,000	$50,000
Processing of Ongoing Eligibility Information	$100,000	$100,000	$100,000	$100,000	$100,000
Electronic Eligibility Load Accuracy 99.5%	$100,000	$100,000	$100,000	$100,000	$100,000
Ongoing ID Cards Issuance	$50,000	$50,000	$50,000	$50,000	$50,000
Average Speed to Answer	$100,000	$100,000	$100,000	$100,000	$100,000
Call Abandonment Rate	$100,000	$100,000	$100,000	$100,000	$100,000
Member Satisfaction – NPS	$100,000	$100,000	$100,000	$100,000	$100,000
Management Reports	$50,000	$50,000	$50,000	$50,000	$50,000
External Vendor Claims File Format MCHCP	$50,000	$50,000	$50,000	$50,000	$50,000
Account Management Satisfaction	$100,000	$100,000	$100,000	$100,000	$100,000
Member Service Center Readiness	$50,000	$50,000	$50,000	$50,000	$50,000
Claims Readiness	$50,000	$50,000	$50,000	$50,000	$50,000
Written Inquiries	$50,000	$50,000	$50,000	$50,000	$50,000
External Vendor Data reporting	$50,000	$50,000	$50,000	$50,000	$50,000
Annual Eligibility Audit File	$25,000	$25,000	$25,000	$25,000	$25,000
Network Management Reports MCHCP	$50,000	$50,000	$50,000	$50,000	$50,000
Precertification List Delivery	$25,000	$25,000	$25,000	$25,000	$25,000
External Vendor Claims File Completeness Financial MCHCP	$50,000	$50,000	$50,000	$50,000	$50,000
External Vendor Claims File Completeness All Fields MCHCP	$50,000	$50,000	$50,000	$50,000	$50,000
External Vendor Claims File 15th MCHCP	$50,000	$50,000	$50,000	$50,000	$50,000
Monthly Eligibility Audit File	$25,000	$25,000	$25,000	$25,000	$25,000
External Vendor Data Transfer Setup	$50,000	$50,000	$50,000	$50,000	$50,000

Marketing Communications Approval	$25,000	$25,000	$25,000	$25,000	$25,000
Account Management Issue Resolution	$25,000	$25,000	$25,000	$25,000	$25,000
Account Management Response Time	$25,000	$25,000	$25,000	$25,000	$25,000
HEDIS Reporting MCHCP	$50,000	$50,000	$50,000	$50,000	$50,000
Secure Messaging Response	$100,000	$100,000	$100,000	$100,000	$100,000
Quality of Care Initiative	$50,000	$50,000	$50,000	$50,000	$50,000
Email Response	$100,000	$100,000	$100,000	$100,000	$100,000
Total Amount At Risk – Operations	**$2,150,000**	**$2,150,000**	**$2,150,000**	**$2,150,000**	**$2,150,000**

- Additional Terms and Conditions:

Performance will be based on the results of a designated service team/business unit assigned to MCHCP Missouri Consolidated Health Care Plan, unless the guarantee is noted as measured with Employer-specific Data.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Renewal Implementation	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	A minimum of 100% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties. The implementation plan will be developed by Anthem and will contain tasks to be completed by Employer and/or Anthem and a timeframe for completion of each task. The implementation plan will also contain Measurement Periods specific to each task. Anthem 's payment under this Guarantee is conditioned upon Employer's completion of all designated tasks by the dates specified in the implementation plan. This will be measured with Employer-specific Data	**Result** / **Penalty** 100% / None 1 task not completed / 50% 2 or more tasks not completed / 100%	**Measurement Period** Defined in Implementation Plan **Reporting Period** 60 calendar days following the end of the implementation period
Renewal Implementation Survey	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	A minimum average score of 3.0 will be attained on the Implementation Survey. Anthem will prepare and send an Implementation Survey to Employer. Anthem will only consider survey results received within 30 calendar days from the delivery of the survey to the Employer. This will be measured with Employer-specific Data.	**Result** / **Penalty** 3.0 or Greater / None 2.6 to 2.9 / 50% Less than 2.6 / 100%	**Measurement Period** Defined in Implementation Plan **Reporting Period** 60 calendar days following the end of the implementation period

Claims Timeliness (14 Calendar Days)	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	A minimum of 95% of Non-investigated medical Claims will be Processed Timely. Non-investigated Claims are defined as medical Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been adjudicated within 14 calendar days of receipt. This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	**Result** / **Penalty** 95.0% or Greater — None 93.0% to 94.9% — 50% Less than 93.0% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly
Claims Financial Accuracy	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	A minimum of 99% of medical Claim dollars will be processed accurately. This Guarantee will be calculated based on the total dollar amount of audited medical Claims paid correctly divided by the total dollar amount of audited medical Paid Claims. The calculation of this Guarantee includes both underpayments and overpayments. The calculation of this Guarantee does not include Claim adjustments or Claims in any quarter in which an Employer requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	**Result** / **Penalty** 99.0% or Greater — None 98.0% to 98.9% — 50% Less than 98.0% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly
Claims Accuracy	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	A minimum of 97% of medical Claims will be paid or denied correctly. This Guarantee will be calculated based on the number of audited medical Claims paid and denied correctly divided by the total number of audited medical Claims paid and denied. The calculation of this Guarantee excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	**Result** / **Penalty** 97.0% or Greater — None 96.0% to 96.9% — 50% Less than 96.0% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly

Open Enrollment ID Card Issuance	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	100% of Subscriber digital ID cards will be available or Member physical ID cards will be mailed to open enrollment participants no later than the Employer's effective date provided that Anthem receives an Accurate Eligibility File. An Accurate Eligibility File is defined as: (1) an electronic eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem no later than 30 calendar days prior to the Employer's effective date; and, (3) contains an error rate of less than 1%. This Guarantee will be calculated based on the total number of open enrollment ID cards available to Subscribers or mailed to Members within the timeframe set forth above divided by the total number of Members eligible to receive open enrollment ID cards. This will be measured with Employer-specific Data.	**Result** / **Penalty** 100% / None 99.0% to 99.9% / $100 per ID Card not to exceed 25% of amount at risk for this measure Less than 99.0% / 100%	**Measurement Period** Employer's effective date **Reporting Period** 60 calendar days following the Employer's effective date
Processing of Ongoing Eligibility Information	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	100% of Employer's ongoing electronic eligibility files will be processed timely. Timely Processing is defined as electronic eligibility files processed and updated on the eligibility database within 1 business days of receipt of an eligibility file. This Guarantee only applies to the processing of eligibility files submitted by Employer outside of an open enrollment period. This Guarantee does not apply to the first production files after setup and testing, COBRA files, or Defective Eligibility Files. A Defective Eligibility File is defined as an eligibility file that has data errors, includes all records that do not pass Anthem's enrollment business rules, or does not allow for Anthem's automatic processing. This Guarantee does not apply to errors that have to be processed manually in the system. Anthem's payment of this Guarantee is conditioned upon receipt of eligibility files in a format mutually agreed upon by the Parties. This Guarantee will be calculated by (1) dividing the total number of eligibility files processed within the timeframe set forth above by (2) the number of Employer's eligibility files processed.	**Result** / **Penalty** 100% / None 98.0% to 99.9% / 50% Less than 98.0% / 100%	**Measurement Period** **Reporting Period**

Electronic Eligibility Load Accuracy 99.5%	Year 1: $100,000.00	At a minimum, 99.5% of Employer's ongoing enrollment data, which is electronically processed, will be updated accurately.	**Result** / **Penalty** 99.5% or Greater / None	**Measurement Period**

	Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	Accurate Processing is defined as data loaded based on upon Elevance's standard data conversion processes with any customizations requested by the client and applied during the implementation process. This Performance Guarantee does not apply to any test files, the first production file after a new setup or any manual enrollment processing of file errors. Furthermore, any data sent to Elevance that is not in the mutually agreed format or excluded from the implementation process guide will not be considered as part of the Performance Guarantee. Anthem's payment of this Guarantee is conditioned upon receipt of eligibility files adhering to mutually agreed formatting rules. This Guarantee will be calculated annually by (1) dividing the total number of accurate data records received and processed annually in the Elevance membership system divided by (2) the total number of data records that are sent through the file. This guarantee requires weekly eligibility files to be sent for a minimum of 3 months. This will be measured with Employer-specific Data.	98.5% to 99.4% 50% Less than 98.5% 100%	**Reporting Period**
Ongoing ID Cards Issuance	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	A minimum of 99% of Subscriber digital ID cards will be available or Member physical ID cards will be mailed to Members within 10 business days of Anthem 's processing of an Accurate Eligibility File. An Accurate Eligibility File is defined as: (1) an eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem outside of an open enrollment period; and, (3) contains an error rate of less than 1%. This Guarantee will be calculated based on the total number of ongoing ID cards available to Subscribers or mailed to Members within the timeframe set forth above divided by the total number of Members eligible to receive ongoing ID cards. This will be measured with Employer-specific Data.	**Result** **Penalty** 99.0% or Greater None 98.0% to 98.9% 50% Less than 98.0% 100%	**Measurement Period** Annual **Reporting Period** Quarterly

Average Speed to Answer	Year 1: $100,000.00 Year 2: $100,000.00	The average speed to answer (ASA) will be 30 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service	**Result** **Penalty** 30 seconds or less None	**Measurement Period** Annual **Reporting Period** Quarterly

	Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	representative (CSR) or an interactive voice response (IVR) unit. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system. This will be measured with Employer-specific Data.	31 to 33 seconds 50% More than 33 seconds 100%	
Call Abandonment Rate	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	A maximum of 4% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. Calls that are abandoned in less than 5 seconds will not be included in this calculation. This will be measured with Employer-specific Data.	**Result** / **Penalty** 4.0% or Less: None 4.01% to 4.40%: 50% 4.41% or Greater: 100%	**Measurement Period** Annual **Reporting Period** Quarterly
Member Satisfaction – NPS	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	This Guarantee establishes a Quality Benchmark transactional Net Promoter Score (NPS) of 50. Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be an improvement in the Net Promoter Score from the Baseline Period. The survey is conducted after a member contacts a customer service representative (CSR). Each member who completes a transaction with Anthem will be asked to provide a rating on a scale from 0 (Not at All Likely) to 10 (Extremely Likely) to a question that asks how likely the member would recommend Anthem to a friend or colleague based on the member's most recent transaction. The transactional Net Promoter Score will be calculated by subtracting the percentage of Detractors (members who provide a rating from 0 to 6) from the percentage of Promoters (members who provide a rating of 9 or 10). To determine the results for (i), Anthem shall compare the Net Promoter Score in the Measurement Period to the Quality Benchmark. The improvement for (ii) will be determined by comparing the Net Promoter Score in the Measurement Period to the Net Promoter Score in the Baseline Period.	**Result** / **Penalty** Net Promoter Score Increased: None OR If Net Promoter Score stayed to same or decreased AND is 50 or Greater: None 49.0 to 49.9: 50% Less than 49.0: 100%	**Measurement Period** **Reporting Period**

		The Baseline Period is the equivalent time period preceding the Measurement Period. This will be measured with Employer-specific Data.		
Management Reports	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	Standard automated reports will be made available to Employer by no later than 25 calendar days following the end of the month. The reports will include financial, utilization and clinical information. This will be measured with Employer-specific Data.	**Result** / **Penalty** Reports are late 1 month — None Reports are late 2 months — 50% Reports are late 3 or more months — 100%	**Measurement Period** Annual **Reporting Period** Annual
External Vendor Claims File Format MCHCP	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	Claim file must be submitted to MCHCP's data vendor in the format mutually agreed upon. This will be measured with Employer-specific Data.	100% of the amount at risk	**Measurement Period** Annual **Reporting Period** Annual
Account Management Satisfaction	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	A minimum average score of 3 will be attained on the Account Management Satisfaction Survey (AMSS). A minimum of 3 responses per Employer to the AMSS is required to base the score on Employer-specific responses only. If 3 responses are received from the Employer, an average score is calculated by adding the scores from each respondent divided by the total number of Employer respondents. If fewer than 3 responses are received, the score will be calculated as follows: 2 Employer responses: 2/3 of the score will be based on Employer-specific AMSS results and 1/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team. 1 Employer- response: 1/3 of the score will be based on Employer- specific AMSS results and 2/3 of the score will be based on the aggregate score of all AMSS results received	**Result** / **Penalty** 3.0 or Higher — None 2.5 to 2.9 — 50% Less than 2.5 — 100%	**Measurement Period** Annual **Reporting Period** Annual

		by the Account Management Team. 0 Employer responses: The score will be based on the aggregate score of all AMSS results received by the Account Management Team.		
Member Service Center Readiness	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	Member Service Center ready to respond to member inquiries prior to open enrollment This will be measured with Employer-specific Data	100% of the amount at risk	**Measurement Period** Employer's effective date **Reporting Period** 60 calendar days following the Employer's effective date
Claims Readiness	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	Claim Readiness - Benefit profile and eligibility information loaded and tested on claims processing system a minimum of one month prior to the effective date. This will be measured with Employer-specific Data	**Result** / **Penalty** One month or more before the effective date: None 2 weeks to less than one month before: 50% Effective date to less than 2 weeks before: 100%	**Measurement Period** Employer's effective date **Reporting Period** 60 calendar days following the Employer's effective date
Written Inquiries	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	A minimum of 90% of written Member inquiries will be closed within 30 calendar days. Written inquires include written correspondence to Anthem and do not include email, internet or appeals correspondence. This Guarantee will be calculated based on the number of Member written inquiries closed within 30 calendar days divided by the total number of Member written inquiries. 100% of written inquiries sent to: Anthem, Attn: Account Management, 1831 Chestnut St., St. Louis, MO 63103 will be closed within 15 calendar days.	**Result** / **Penalty** 90.0% or Greater: None 87.0% to 89.9%: 50% Less than 87.0%: 100%	**Measurement Period** Annual **Reporting Period** Quarterly

		This will be measured with Employer-specific Data.		
External Vendor Data reporting	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	Claim file must be submitted to MCHCP's data vendor no later than 20th day of the month for prior month's services. The penalty will apply if guarantee is missed at any one time during annual measurement period (not per occurrence). This will be measured with Employer-specific Data.	**Result** / **Penalty** Reports are late 1 month / None Reports are late 2 months / 50% Reports are late 3 or more months / 100%	**Measurement Period** Annual **Reporting Period** Annual
Annual Eligibility Audit File	Year 1: $25,000.00 Year 2: $25,000.00 Year 3: $25,000.00 Year 4: $25,000.00 Year 5: $25,000.00	Eligibility audit file must be provided by February 1st each year. This will be measured with Employer-specific Data.	**Result** / **Penalty** Reports are late 1 month / 25% Reports are late 2 months / 50% Reports are late 3 or more months / 100%	**Measurement Period** Annual **Reporting Period** Annual
Network Management Reports MCHCP	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	The following reports will be delivered to MCHCP by a mutually agreed to date. a) Provider network adequacy reporting as compared to 20 CSR 400-7.095 b) If applicable, reporting identifying alternative provider arrangements (ACOs,PCMH, etc.) c) Network Management Reports d) Geographic access reporting confirming network sufficiency This will be measured with Employer-specific Data.	**Result** / **Penalty** All reports on time / None For each day beyond deadline for submission / $5,000 plus $0.25 PEPM not to exceed total dollars at risk for this PG	**Measurement Period** Annual **Reporting Period** Quarterly
Precertification List Delivery	Year 1: $25,000.00 Year 2: $25,000.00 Year 3: $25,000.00	Anthem will deliver the current year's precertification list to the Employer no later than January 30th of the contract year. This will be measured with Employer-specific Data.	**Result** / **Penalty** By January 30th / None For each day beyond / $5,000 plus $0.25 PEPM	**Measurement Period** Annual **Reporting Period** Annual

	Year 4: $25,000.00 Year 5: $25,000.00		January 30th not to exceed total dollars at risk for this PG.	
External Vendor Claims File Completeness Financial MCHCP	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	Claim file must be submitted to MCHCP's data vendor in the format mutually agreed upon must include 99.0% percent of all required financial fields. This will be measured by calculating missing required financial fields of all claims divided by the number of all required financial fields of all claims. This will be measured with Employer-specific Data.	**Result** / **Penalty** 99.0% or Greater / None 98.0% to 98.9% / 25% Less than 98.0% / 100%	**Measurement Period** Annual **Reporting Period** Quarterly
Annual Eligibility Audit File	Year 1: $25,000.00 Year 2: $25,000.00 Year 3: $25,000.00 Year 4: $25,000.00 Year 5: $25,000.00	Eligibility audit file must be provided by February 1st each year. This will be measured with Employer-specific Data.	**Result** / **Penalty** Reports are late 1 month / 25% Reports are late 2 months / 50% Reports are late 3 or more months / 100%	**Measurement Period** Annual **Reporting Period** Annual
External Vendor Claims File Completeness All Fields MCHCP	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	Claim file must be submitted to MCHCP's data vendor in the format mutually agreed upon must include 100.0% percent of all required and key fields. Required Fields = Subscriber SSN or appropriate identifier, member DOB, and member gender Key Fields = diagnostic coding, provider type, provider ID, and other mutually agreed upon fields This will be measured by calculating missing required fields of all claims divided by the number of all required fields of all claims. This will be measured with Employer-specific Data.	**Result** / **Penalty** 100% / None 99.0% to 99.9% / 50% Less than 99.0% / 100%	**Measurement Period** Annual **Reporting Period** Quarterly
External Vendor Claims File 15th MCHCP	Year 1: $50,000.00 Year 2: $50,000.00	Claim file must be submitted to MCHCP's data vendor no later than 15th day of the month for prior month's services. The penalty will apply if guarantee is missed at any one time during	**Result** / **Penalty** File 1 month late / None	**Measurement Period** Annual **Reporting Period**

	Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	annual measurement period (not per occurrence). This will be measured with Employer-specific Data.	File late 2 months 50% File late 3 or more months 100%	Quarterly
Monthly Eligibility Audit File	Year 1: $25,000.00 Year 2: $25,000.00 Year 3: $25,000.00 Year 4: $25,000.00 Year 5: $25,000.00	Eligibility audit file must be available by the second Thursday of each month This will be measured with Employer-specific Data.	**Result** **Penalty** File late 1 month None File late 2 months 50% File late 3 or more times 100%	**Measurement Period** Annual **Reporting Period** Quarterly
External Vendor Data Transfer Setup	Year 1: $50,000.00	All data transfer setup requirements with MCHCP's data completed by Effective date. This will be measured with Employer-specific Data.	100% of the amount at risk	**Measurement Period** Employer's effective date **Reporting Period** 60 calendar days following the Employer's effective date
External Vendor Claims File Completeness All Fields MCHCP	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	Claim file must be submitted to MCHCP's data vendor in the format mutually agreed upon must include 100.0% percent of all required and key fields. Required Fields = Subscriber SSN or appropriate identifier, member DOB, and member gender Key Fields = diagnostic coding, provider type, provider ID, and other mutually agreed upon fields This will be measured by calculating missing required fields of all claims divided by the number of all required fields of all claims. This will be measured with Employer-specific Data.	**Result** **Penalty** 100% None 99.0% to 99.9% 50% Less than 99.0% 100%	**Measurement Period** Annual **Reporting Period** Quarterly
External Vendor Claims File 15th MCHCP	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00	Claim file must be submitted to MCHCP's data vendor no later than 15th day of the month for prior month's services. The penalty will apply if guarantee is missed at any one time during annual measurement period (not per occurrence).	**Result** **Penalty** File 1 month late None File late 2 months 50%	**Measurement Period** Annual **Reporting Period** Quarterly

	Year 4: $50,000.00 Year 5: $50,000.00	This will be measured with Employer-specific Data.	File late 3 or more months — 100%	
Marketing Communications Approval	Year 1: $25,000.00 Year 2: $25,000.00 Year 3: $25,000.00 Year 4: $25,000.00 Year 5: $25,000.00	Custom marketing communications specific to the Employer where Anthem is not restricted by legal or regulatory requirements will be shared with the Group prior to distribution, as mutually agreed to by the parties. This will be measured with Employer-specific Data; penalty is not assessed per incident.	**Result** — **Penalty** At least one incident — 100%	**Measurement Period** Annual **Reporting Period** Quarterly
Account Management Issue Resolution	Year 1: $25,000.00 Year 2: $25,000.00 Year 3: $25,000.00 Year 4: $25,000.00 Year 5: $25,000.00	Employer issues communicated to the account management team, resolvable by the account team, will be resolved, on average, within 10 business days or have a plan to resolution communicated to the Employer. This Guarantee will not include business days during which the account team member is off for bereavement or illness. This will be measured with Employer-specific Data.	**Result** — **Penalty** Resolution in 10 or fewer business days — None Resolution greater than 10 and up to 11 business days — 50% Resolution greater than 10 business days — 100%	**Measurement Period** Annual **Reporting Period** Quarterly
Account Management Response Time	Year 1: $25,000.00 Year 2: $25,000.00 Year 3: $25,000.00 Year 4: $25,000.00 Year 5: $25,000.00	Employer telephone calls and emails to Anthem 's account management team will have a Response within an average of 8 business hours. Response is defined as an attempt to return a telephone call or email following a received call or email. Inquiries exclude any items that would be handled by customer service, medical management or any claims related questions. This Guarantee will not include business hours during which the account team member is off for bereavement or illness. This Guarantee will be based on the number of telephone calls and emails with a Response within 8 business hours divided by the number	**Result** — **Penalty** 8 Hours or Less — None Greater than 8 hours and less than or equal to 10 hours — 50% Greater than 10 hours — 100%	**Measurement Period** Annual **Reporting Period** Quarterly

		of telephone calls and emails received by Anthem 's account management team. A business hour is considered an hour within the usual 9 AM to 5 PM time zone hours during a business day. This will be measured with Employer-specific Data.		
HEDIS Reporting MCHCP	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	Anthem will work with MCHCP to determine a set of NCQA HEDIS measures to be reported using agreed to accredited Missouri plans to be delivered by September 15 of the following calendar year. Anthem will not be penalized for any NCQA HEDIS measure NCQA HEDIS does not measure; either through lack of data or as determined by NCQA HEDIS to no longer measure.	**Result** / **Penalty** On or before September 15 — None 1 to 5 business days late — 50% Greater than 5 business days late — 100%	**Measurement Period** Annual **Reporting Period** Quarterly
Secure Messaging Response	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00 Year 4: $100,000.00 Year 5: $100,000.00	A minimum of 90% of secure member messages will be responded to within 1 business day. This Guarantee will be calculated based on the total number of secure member messages received from members that are responded to within 1 business day divided by the total number of secure member message received from members. This will be measured with Employer-specific Data.	**Result** / **Penalty** 90.0% or Greater — None 87.0% to 89.9% — 50% Less than 87.0% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly
Quality of Care Initiative	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	A minimum of one mutually agreed to quality of care initiative ("Initiative") will be initiated and implemented by Anthem withinthe Measurement Period. This Guarantee will be based on Anthem providing atleast one update showing progress made on the Initiative within the Measurement Period. This will be measured with Employer-specific Data.	**Result** / **Penalty** No initiative in calendar year — 100%	**Measurement Period** Annual **Reporting Period** Annual
Email Response	Year 1: $100,000.00 Year 2: $100,000.00 Year 3: $100,000.00	A minimum of 90% of secure member messages will be responded to within 3 business days. This Guarantee will be calculated based on the total number of secure member messages received from members that are responded to within 3 business days	**Result** / **Penalty** 90.0% or Greater — None 87.0% to 89.9% — 50%	**Measurement Period** Annual **Reporting Period** Annual

	Year 4: $100,000.00 Year 5: $100,000.00	divided by the total number of secure member message received from members. This will be measured with Employer-specific Data.	Less than 100% 87.0%	

ATTACHMENT 2
TO
SCHEDULE C

Performance Guarantees
Network Guarantees

This Attachment is made part of Schedule C and will be effective for the Performance Period of January 1, 2025 through December 31 2025. This Attachment is intended to supplement and amend the Contract between the Parties.

Network Guarantees

Performance Category	Year 1	Year 2	Year 3	Year 4	Year 5
Network Provider Discount	$750,000	N/A	N/A	N/A	N/A
Network Provider Utilization	$200,000	N/A	N/A	N/A	N/A
Provider Accessibility	$50,000	$50,000	$50,000	$50,000	$50,000
Total Amount At Risk - Network	**$1,000,000**	**$50,000**	**$50,000**	**$50,000**	**$50,000**

Additional Terms and Conditions

a. This/These Guarantee(s) applies to following time periods:(Measurement Period Year 1: Claims Incurred from January 01, 2025 through December 31, 2025 and Paid from January 01, 2025 and through March 31, 2026.

b. Year 2: Claims Incurred from January 01, 2025 through December 31, 2025 and Paid from January 01, 2025 and through March 31, 2027.

c. Year 3: Claims Incurred from January 01, 2025 through December 31, 2025 and Paid from January 01, 2025 and through March 31, 2028.

d. Each Network Guarantee excludes all charges for any Member whose allowed Claims exceed $250,000.00 during the Measurement Period.

e. TPA has the right in its sole discretion to modify or terminate the Network Guarantee(s) if any of these occur:

   i. TPA is no longer the sole administrator for MCHCP's Plan.

   ii. MCHCP fails to maintain at least an average enrollment of 33,000 Subscribers.

   iii. The geographic distribution of Subscribers changes by more than 5% in any state or by more than 10 subscribers in such state, whichever is greater.

   iv. Total subscriber enrollment changes by more than 15% from the MCHCP census provided for purposes of establishing this Guarantee.

f. A change is initiated by MCHCP that results in a substantial change in the services to be performed by TPA or the measurement of a Performance Guarantee. Under the "substantial change" caveat, Anthem requests the right to modify the discount guarantee in the unlikely event that MCHCP makes a significant benefit or program change that materially increases cost of care or out-of-network utilization (e.g., MCHCP discontinues benefits for a certain type of service or engages a vendor that steers members to higher cost or out of state providers.)

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Network Provider Discount	Year 1: $750,000.00	Anthem guarantees a minimum Network Provider Discount of 61.300%. This Guarantee excludes all charges for any Member whose allowed Claims exceed $250,000.00 during the Measurement Period. Eligible Claim Charges are defined as charges for Covered Services provided to Members enrolled in PPO EPO POS Plans. Eligible Claim Charges will be based on Anthem primary Claims only and will not include charges related to Prescription Drug Claims, Inter-Plan Program fees, state surcharges, Anthem Provider payment innovation programs or services rendered outside the United States. Allowed Amount is defined as the amount paid by Anthem to PPO EPO POS Network Providers on Eligible Claim Charges plus any Member cost shares. This Guarantee will be calculated by dividing the PPO EPO POS Network Provider Allowed Amounts by the PPO EPO POS Network Eligible Claim Charges. The resulting percentage shall be subtracted from 100% to determine the Network Provider Discount. Anthem reserves the right to re-evaluate the guaranteed discount if the actual combined in-network service mix is not within 3 percentage points of any one or more of the following: 18.100% inpatient hospital, 49.400% outpatient hospital and 32.500% professional. Only Claims submitted to a Blue Cross and/or Blue Shield licensee for processing and adjudication shall be considered for purposes of this Discount Guarantee. This Guarantee assumes that, per the uniform data standard specifications released on 02/24/2022, Provider billed charge trend will be as follows: 4% inpatient hospital, 6.5% outpatient hospital and 4% professional. This Guarantee is subject to modification if actual billed charge trend falls below these amounts. This will be measured with Employer-specific Data.	**Result** / **Penalty** If Actual Results are lower than the final Guarantee by: / 0.0% to 1.0% / None 1.1% to 2.0% / 25% More than 2.0% / 100%	**Measurement Period** Annual-This period applies to Claims incurred from January 01, 2025 through December 31, 2025 and Paid from January 01, 2025 and through March 31, 2026 **Reporting Period** Annual
Network Provider Utilization	Year 1: $200,000.00	A minimum of 98.200% of Eligible Claim Charges will be for services provided by	**Result** / **Penalty**	**Measurement Period**

		Providers payable at the in-Network level of benefits. Eligible Claim Charges are defined as charges for Covered Services provided to Members enrolled in PPO EPO POS Plans. Eligible Claim Charges will be based on Anthem primary Claims only and will not include charges related to Prescription Drug Claims, Inter-Plan Program fees, state surcharges, or Claims incurred outside the United States, Puerto Rico and US Virgin Islands. This Guarantee will be calculated by dividing the total Eligible Claim Charges payable at the in-Network level of benefits by the total Eligible Claim Charges. The total Eligible Claim Charges payable at the in-Network level of benefits may not include certain charges related to out of Network providers that are reimbursed at the in-Network level of benefits. This Guarantee excludes all charges for any Member whose allowed Claims exceed 250,000.00 during the Measurement Period. This will be measured with Employer-specific Data.	If Actual Results are lower than the final Guarantee by: 0 to 1.0% None 1.1% to 2.0% 25% More than 2.1% 100%	Annual-This period applies to Claims incurred from January 01, 2025 through December 31, 2025 and Paid from January 01, 2025 and through March 31, 2026 **Reporting Period** Annual
Provider Accessibility	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	There will be a 5% or less change in member access to network providers. Member Access will be established by running a GeoAccess report prior to the beginning of each Measurement Period. Member Access is defined as access to: (i) at least 1 primary care Provider in the following geographic areas: Urban: 10 miles Basic: 20 miles Rural: 30 miles; and (ii) at least 1 specialist Provider for chiropractic, general surgery, and OB/GYN in the following geographic areas: Urban: 15 miles Basic: 30 miles Rural: 60 miles; and (iii) at least 1 basic hospital in the following geographic areas: Urban: 30 miles Basic: 30 miles Rural: 30 miles; and (iv) at least 1 tertiary hospital in the following geographic areas: Urban: 100 miles	**Result** **Penalty** Less than 5.0% None 5.1% to 5.5% 25% Greater than 5.5% 100%	**Measurement Period** Annual **Reporting Period** Annual

		Basic: 100 miles Rural: 100 miles This guarantee will be calculated based on the results of a GeoAccess report run at the beginning of a Measurement Period compared to the results of a GeoAccess report run at the end of a Measurement Period. This guarantee will not include vision, dental or pharmacy providers. This will be measured with Employer-specific Data.		

ATTACHMENT 3
TO
SCHEDULE C

Performance Guarantees
Care Management Guarantees

This Attachment is made part of Schedule C and will be effective for the Performance Period of January 1, 2025 through December 31 2025. This Attachment is intended to supplement and amend the Contract between the Parties.

Care Management Guarantees

Performance Category	Year 1	Year 2	Year 3	Year 4	Year 5
Clinical Outcomes					
(TH Complete) CAD – Statin Medications	$30,000	$30,000	$30,000	$30,000	$30,000
(TH Complete) Diabetes Annual Hemoglobin A1c (HbA1c) Testing	$30,000	$30,000	$30,000	$30,000	$30,000
(TH Complete) Heart Failure ACE Inhibitors/ARB	$30,000	$30,000	$30,000	$30,000	$30,000
(TH Complete) Persistent Asthma Prescription Drug Dispensed	$30,000	$30,000	$30,000	$30,000	$30,000
Total Health (TH) Complete					
TH Complete 30 Day Inpatient Readmission	$30,000	$30,000	$30,000	$30,000	$30,000
TH Complete Avoidable ER Visit	$30,000	$30,000	$30,000	$30,000	$30,000
TH Complete Comprehensive Engagement	$50,000	$50,000	$50,000	$50,000	$50,000
TH Complete High Dollar Claimant Outreach	$50,000	$50,000	$50,000	$50,000	$50,000
TH Complete Inpatient Admissions	$30,000	$30,000	$30,000	$30,000	$30,000
TH Complete Member Outreach for Pre-Admission Counseling	$30,000	$30,000	$30,000	$30,000	$30,000
TH Complete Member Satisfaction	$50,000	$50,000	$50,000	$50,000	$50,000
TH Complete Timeliness of Prenatal Care	$30,000	$30,000	$30,000	$30,000	$30,000
TH Complete Member Outreach for Post-Discharge Counseling	$30,000	$30,000	$30,000	$30,000	$30,000
TH Complete ROI	25% of TH Complete Fees	25% of TH Complete Fees	25% of TH Complete Fees	25% of TH Complete Fees	25% of TH Complete Fees
Total Amount At Risk – Care Management	**25.0% of Identified Applicable fees $450,000**	**25.0% of Identified Applicable fees $450,000**	**25.0% of Identified Applicable fees $450,000**	**25.0% of Identified Applicable fees $450,000**	**25.0% of Identified Applicable fees $450,000**

Additional Terms and Conditions

a. Standard minimum enrolled Members required:
   i. ConditionCare Metrics: Enrollment, Engagement, Outcome & Clinical Outcome Metrics, Clinical Care Intervention ROI and Member Satisfaction Survey – 5,000 non-Medicare primary Members

ii. Total Health Complete – 15,000 non-Medicare primary Members for Avoidable ER Visits, 30 Day Inpatient Readmissions and Inpatient Admissions and 7,500 non-Medicare primary Members for ROI. If enrollment is less than stated, the metrics will be evaluated based on book of business results.

iii. Some of the proposed Performance Guarantees may be duplicative in nature and based on the final sold product configuration; the final Performance Guarantee Package will be refined to eliminate redundancy.

iv. Identified Members are Members who are identified by TPA as appropriate for inclusion in the measured population, the selection criteria for which may be modified from time to time.

v. Members who are Medicare-primary are not eligible for inclusion in calculations related to these Performance Guarantees.

vi. MCHCP shall provide the historical eligibility information and the historical medical and Prescription Drug Claims in the format and for the time frame required by TPA followed by monthly refreshes of Claims and Prescription Drug data from third party payers other than TPA. All data must be materially complete and in the mutually agreed upon format. Failure by MCHCP to provide any data in the timeframe and format required by TPA within the applicable time frame will nullify the applicable Performance Guarantee.

vii. Unless otherwise provided in the description of a Performance Guarantee in this attachment, the Performance Guarantees herein require 30 or more of MCHCP Members being measured in order for TPA to have an obligation to make a payment under such Performance Guarantee.

viii. All Performance Guarantees in which TPA will make outbound calls to Identified Members will exclude Identified Members whom TPA cannot reach due to incorrect or invalid telephone numbers, including numbers where permission is required by law but not provided, or those Identified Members who have requested that TPA not contact them.

ix. TPA reserves the right to revise Performance Guarantees to reflect modifications and advances in medical standards and practices when such standards and practices become generally accepted.

x. The term Quality Benchmark means the specified Performance Guarantee targeted outcome for a specific Performance Guarantee.

Total Health (TH) Complete

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
TH Complete Member Outreach for Post-Discharge Counseling	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	A minimum of 95% of Identified Members will receive successful contact from an Anthem health coach or receive at least 2 outreach attempts from an Anthem health coach within 3 business days following notification of discharge, excluding the day of discharge, from a medical or surgical inpatient stay to the home setting where the Identified Member had a length of stay of 3 days or greater. This Guarantee does not include admissions related to maternity or behavioral health services. This Guarantee only includes Members discharged to the home setting and not to Members discharged to an inpatient rehabilitation center or a skilled nursing facility. This Guarantee will be calculated based on the number of Identified Members who receive successful contact or receive at least 2 outreach attempts within 3 business days following discharge, excluding day of discharge, divided by all Identified Members with a length of stay of 3 days or greater. This will be measured with Employer-specific Data.	**Result** / **Penalty** 95.0% or Greater — None 94.0% to 94.9% — 50% Less than 94.0% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly
TH Complete ROI	Year 1: 25.0% of TH Complete Fees Year 2: 25.0% of TH Complete Fees Year 3: 25.0% of TH Complete Fees Year 4: 25.0% of TH Complete Fees Year 5: 25.0% of TH Complete Fees	The Return on Investment (ROI) will be 2.0:1. The ROI is defined as gross savings divided by the program fees. The calculation methodology used to estimate gross savings shall be based upon Anthem's methodology. This Guarantee requires: (i) A minimum of 33% Household Engagement in the Anthem digital solution that is part of TH Complete. Household Engagement is defined as the number of Users that logged into the Anthem digital program during the Measurement Period other than for the purpose of initial registration divided by number of Subscribers with access to the Anthem digital program. Users are Subscribers who have registered for the Anthem digital program; and (ii) Employer provides email addresses for at least 60% of its eligible Subscribers and attests that Anthem may contact Members using their email addresses; and (iii) Employer provides valid phone numbers for at least 80% of its eligible Subscribers and attests that Anthem may contact Members using these	**Result** / **Penalty** 2.00:1 or Greater — None 1.80:1 to 1.99:1 — 50% Less than 1.80:1 — 100%	**Measurement Period** Annual **Reporting Period** Annual

		phone numbers; and (iv) Employer supports dedicated launch communication for the Anthem digital program via multiple channels (e.g. email, print, intranet portals, enrollment guides) that reaches 60% of Subscribers; and (v) Employer agrees to use Anthem's National Accounts standard precertification list This will be measured with Employer-specific Data.		

Clinical Outcomes

The Clinical Outcome Guarantees are only valid if there are at least 100 Identified Members in a Measurement Period. Only Members, for whom TPA has at least 12 months of eligibility information in a Measurement Period, shall be considered Identified Members for purposes of the Guarantees. The Baseline Period for a new account will be the period immediately preceding the first TPA Measurement Period. Required data must be received in order for this Guarantee to be applicable during the first Measurement Period. In the event data is not received or available, those impacted Guarantees will be measured in the second TPA plan year.

*Calculation Example

Quality Benchmark = Dispense Rate target of 50%. Improvement rate target is 2.5%

•Example 1. Measurement Period Dispense Rate is 60%. Guarantee is satisfied as the Dispense Rate exceeds the Quality Benchmark.

•Example 2. Baseline Period Dispense Rate is 40% and Measurement Period Dispense Rate is 41%. The difference between the Measurement Period and Baseline Period Dispense Rate is 1.0%. (41.0% - 40.0% = 1.0%) The difference between the Quality Benchmark and the Baseline Period Dispense Rate is 10.0%. (50.0% - 40.0%). Divide the differences (1.0% ÷ 10.0% is 10.0%). Guarantee is satisfied as the improvement is more than 2.5%.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
			Result	Penalty	
(TH Complete) CAD – Statin Medications	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	This Guarantee establishes a Quality Benchmark of 65% in the percentage of Identified Members with coronary artery disease (CAD) who are dispensed one or more statin medications. (Dispense Rate). Anthem will be either (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 2.5% in the Dispense Rate as compared to the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period. The Dispense Rate will be calculated based on the total number of Identified Members with CAD who are dispensed 1 or more statin medications during the Measurement Period divided by the total number of Identified Members. To determine the results for (i), Anthem shall compare the Dispense Rate in the Measurement Period to the Quality Benchmark. The improvement percentage for (ii) will be calculated by: 1) subtracting the Dispense Rate in the Baseline Period from the Dispense Rate in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period.	Adherence Rate Improved by 2.5% or More	None	**Measurement Period** Annual **Reporting Period** Annual
			OR		
			If Adherence Rate Improved by Less Than 2.5% AND is		
			65% or Greater	None	
			62.5% - 64.9%	50%	
			Less than 62.5%	100%	

		This will be measured with Employer-specific Data.		
(TH Complete) Diabetes Annual Hemoglobin A1c (HbA1c) Testing	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	This Guarantee establishes a Quality Benchmark of 75% in the percentage of Identified Members with diabetes and who received at least 1 HbA1c test (Testing Rate). Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 2.5% in the Testing Rate as compared to the difference between the Quality Benchmark and Testing Rate for the Baseline Period. The Testing Rate will be calculated based on the number of Identified Members who received at least 1 HbA1c test during the Measurement Period divided by the total number of Identified Members. To determine the results for (i), Anthem shall compare the Testing Rate in the Measurement Period to the Quality Benchmark. The improvement percentage for (ii) will be calculated by: 1) subtracting the Testing Rate in the Baseline Period from the Testing Rate in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Testing Rate for the Baseline Period. This will be measured with Employer-specific Data.	**Result** / **Penalty** Testing Rate Improved by 2.5% or More — None OR If Testing Rate Improved by Less Than 2.5% AND is 75% or Greater — None 72.5% - 74.9% — 50% Less than 72.5% — 100%	**Measurement Period** Annual **Reporting Period** Annual
(TH Complete) Heart Failure ACE Inhibitors/ARB	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	This Guarantee establishes a Quality Benchmark of 50% in the percentage of Identified Members with heart failure who are dispensed 1 or more angiotensin-converting enzyme inhibitors (ACE inhibitors) or angiotensin receptor blockers (ARBs), or ACE inhibitors/ARB (Dispense Rate). Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 2.5% in the Dispense Rate as compared to the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period. Dispense Rate will be calculated based on the number of Identified Members with heart failure who are dispensed 1 or more ACE inhibitors/ARBs during the Measurement Period divided by the total number of Identified Members.	**Result** / **Penalty** Dispense Rate Improved by 2.5% or More — None OR If Dispense Rate Improved by Less Than 2.5% AND is 50.0% or Greater — None	**Measurement Period** Annual **Reporting Period** Annual

		To determine the results for (i),Anthem shall compare the Dispense Rate in the Measurement Period to the Quality Benchmark. The improvement percentage for (ii) will be calculated by: 1) subtracting the Dispense Rate in the Baseline Period from the Dispense Rate in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period. This will be measured with Employer-specific Data.	47.5% - 49.9% 50% Less than 47.5% 100%	
(TH Complete) Persistent Asthma Prescription Drug Dispensed	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	This Guarantee establishes a Quality Benchmark of 80% in the percentage of Identified Members with persistent asthma who are dispensed 1 or more appropriate Prescription Drugs (Dispense Rate). Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 2.5% in the Dispense Rate as compared to the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period. The Dispense Rate will be calculated based on the number of Identified Members with persistent asthma who are dispensed 1 or more appropriate Prescription Drugs during the Measurement Period divided by the total number of Identified Members. To determine the results for (i), Anthem shall compare the Dispense Rate in the Measurement Period to the Quality Benchmark. The improvement percentage for (ii) will be calculated by: 1) subtracting the Dispense Rate in the Baseline Period from the Dispense Rate in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period. This will be measured with Employer-specific Data.	**Result** **Penalty** Dispense Rate Improved by 2.5% or More None OR . If Dispense Rate Improved by Less Than 2.5% AND is . 80.0% or Greater None 77.5% - 79.9% 50% Less than 77.4% 100%	**Measurement Period** Annual **Reporting Period** Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
TH Complete 30 Day Inpatient Readmission	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	TH Complete 30 Day Inpatient Readmission This Guarantee establishes a Quality Benchmark of 9.0 or less readmissions per 100 admissions (IP Readmission Rate). The IP Readmission Rate is defined as the rate of Inpatient Readmissions for Identified Members that occur within 30 days of discharge from an inpatient stay. The readmissions included to calculate compliance with this Performance Guarantee shall: (a) include acute inpatient stays for Members who are 18 years of age and older during the Measurement Period that were followed by an acute readmission for any diagnosis within 30 days; and, (b) exclude stays that meet the exclusion criteria such as those related to pregnancy and birth, or with a discharge code of death, or rehabilitation-specific admissions. Anthem will either: (i) meet or exceed the Benchmark; or, (ii) there will be a reduction in the Inpatient Readmission Rate for the Measurement Period compared to the Baseline Period. Only Identified Members, for whom Anthem has at least 6 months of eligibility information in a Measurement Period, shall be considered for purposes of this Guarantee. To determine the results for (i), Anthem shall compare the IP Readmission Rate to the Quality Benchmark. To determine the results for (ii), Anthem shall compare the IP Readmission Rate for the Measurement Period to the IP Readmission Rate for the Baseline Period. This will be measured with Employer-specific Data.	**Result** / **Penalty** Rate is reduced / None OR / . If Rate is same or increases AND is / . 9.0 per 100 or less / None 9.1 – 10.0 per 100 / 50% Greater than 10.1 per 100 / 100%	**Measurement Period** Annual **Reporting Period** Quarterly

TH Complete Avoidable ER Visit	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	TH Complete Avoidable ER Visit This Guarantee establishes a Quality Benchmark of 77.5 or less avoidable Emergency Room Visits per 1,000 Members (Avoidable ER Visit Rate). Avoidable Emergency Room Visits are defined as low intensity Emergency Room Visits on the high impact diagnosis list as determined according to Anthem 's criteria. Avoidable Emergency Room Visits do not include any Emergency Room Visits that result in an Inpatient Admission. Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be a reduction in the Avoidable ER Visit Rate for the Measurement Period compared to the Baseline Period. Only Identified Members, for whom Anthem has at least 6 months of eligibility information in a Measurement Period, shall be considered for purposes of this Guarantee. To calculate the Avoidable ER Visit Rate, Anthem shall divide (a) the Avoidable ER Visits during the Measurement Period by (b) the number of Identified Members for such Measurement Period. In determining (b) above, Anthem shall weight the number of those Identified Members by the actual number of months that Anthem had eligibility information for those included Identified Members. To determine the results for (i), Anthem shall compare the Avoidable ER Visit Rate to the Quality Benchmark. To determine the results for (ii), Anthem shall compare the Avoidable ER Visit Rate for the Measurement Period to the Avoidable ER Visit Rate for the Baseline Period. This will be measured with Employer-specific Data.	**Result** / **Penalty** Rate is reduced / None OR / . If Rate is same or increases AND is / . 77.5 per 1,000 or less / None 77.6 – 80 per 1,000 / 50% Greater than 80.0 per 1,000 / 100%	**Measurement Period** Annual **Reporting Period** Quarterly
TH Complete Comprehensive Engagement	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00	TH Complete Comprehensive Engagement Anthem guarantees a minimum Comprehensive Engagement of 60% or a 2.5% year over year improvement in Comprehensive Engagement, including Traditional Engagement, Care Coordination Engagement, and Digital Engagement, through the use of multi-modal	**Result** / **Penalty** Improved by 2.5% or More / None OR / . If improved by Less / .	**Measurement Period** Annual **Reporting Period** Quarterly

	Year 4: $50,000.00 Year 5: $50,000.00	communication channels (including mobile chat, portal click-to-chat, and bilateral text messaging), health notes, and utilization management authorizations. Traditional Engagement is defined as traditional care management telephonic engagement. Care Coordination Engagement leverages Anthem 's partnership Network Providers to coordinate a Member's care, while also encompassing the telephonic connections Members have with health guides. Digital Engagement references Member interactions through the website and mobile application, capturing communication through emails, click-to-chat discussions, bilateral text messaging and telehealth. This Guarantee requires: (i) that Employer provides email addresses for at least 60% of its eligible Subscribers and attests that Anthem may contact Members using their email addresses; (ii) that Employer provides valid phone numbers for at least 80% of its eligible Subscribers and attests that Anthem may contact Members using these phone numbers; and (iii) that Employer supports dedicated launch communication for an Anthem Digital Solution via multiple channels (e.g. email, print, intranet portals, enrollment guides) that reaches 60% of Subscribers. This will be measured with Employer-specific Data.	Than 2.5% AND is 60.0% or Greater — None 57.5% - 59.9% — 50% Less than 57.5.0% — 100%	
TH Complete High Dollar Claimant Outreach	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	TH Complete High Dollar Claimant Outreach A minimum of 90% of Identified Members who accumulate $100,000 or more of paid claims during the Measurement Period will receive successful contact from an Anthem health coach during the Measurement Period or receive at least 2 attempted outreach telephone calls within the Measurement Period from an Anthem health coach in 1 of the Anthem clinical programs. This Guarantee will include both medical and Prescription Drug claims. If Prescription Drug	**Result** — **Penalty** 90.0% or Greater — None 89.0% to 89.9% — 50% Less than 88.0% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly

		benefits are administered by third party payers other than Anthem , this Guarantee will include Prescription Drug claims if Prescription Drug claims data is received from Employer in a format that is acceptable to Anthem. This Guarantee does not include pediatric cases. This Guarantee will be calculated based on the number of Identified Members who receive successful contact from an Anthem health coach during the Measurement Period or receive at least 2 attempted outreach telephone calls within the Measurement Period from an Anthem health coach divided by the number of Identified Members who accumulate $100,000 or more of paid claims in the Measurement Period. This will be measured with Employer-specific Data.		
TH Complete Inpatient Admissions	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	TH Complete Inpatient Admissions This Guarantee establishes a Quality Benchmark of 65 or less Inpatient Admissions per 1,000 Members (IP Admission Rate) Inpatient Admissions are defined as admissions with Type of Service categories of Medical, Surgical and Behavioral Health. Admissions do not include admissions related to Type of Service categories of Maternity, NICU or Rehabilitation. Anthem will either: (i) meet or exceed the benchmark; or, (ii) there will be a reduction in the IP Admission Rate from the Measurement Period compared to the Baseline Period. Only Members, for whom Anthem has at least 6 months of eligibility information in a Measurement Period, shall be considered for purposes of this Guarantee. To calculate the IP Admission Rate, Anthem shall divide (a) the IP Admissions during the Measurement by (b) the number of Identified Members for such Measurement Period. In determining (b) above, Anthem shall weight the number of those Identified Members by the actual number of months that Anthem had eligibility information for those Identified Members. To determine the results for (i), Anthem shall compare the IP Admission Rate to the Quality Benchmark. To determine the results for (ii),	**Result** / **Penalty** Local Model / . Rate is reduced / None OR / . If Rate is same or Increases AND is / . 65 per 1,000 or less / None 65.1 – 70 per 1,000 / 50% Greater than 70.0 per 1,000 / 100%	**Measurement Period** Annual **Reporting Period** Quarterly

		Anthem shall compare the IP Admission Rate for the Measurement Period to the IP Admission Rate for the Baseline Period. This will be measured with Employer-specific Data.		
TH Complete Member Outreach for Pre-Admission Counseling	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	TH Complete Member Outreach for Pre-Admission Counseling A minimum of 90% of Identified Members will receive successful contact from an Anthem health coach or receive at least 2 attempted outreach telephone calls from an Anthem health coach prior to a scheduled medical or surgical admission when precertification approval as described in the Member's Benefits Booklet is completed at least 4 business days prior to the medical or surgical admission date, excluding the date of admission. This Guarantee does not include admissions related to maternity or behavioral health services. This Guarantee will be calculated based on the number of Identified Members who receive successful contact or receive at least 2 attempted outreach telephone calls prior to a scheduled medical or surgical admission divided by all Identified Members who complete the precertification process as described in the Member's Benefits Booklet at least 4 business days prior to their medical or surgical admission date, excluding the date of admission. This will be measured with Employer-specific Data.	**Result** / **Penalty** 90.0% or Greater / None 89.0% to 89.9% / 50% Less than 89.0% / 100%	**Measurement Period** Annual **Reporting Period** Quarterly
TH Complete Member Satisfaction	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	TH Complete Member Satisfaction A minimum average score of 85% will be attained on Anthem's clinical model member satisfaction survey question. Each surveyed member is asked to rate their satisfaction with Anthem 's clinical model program using a 5 point scale. The response is scored by dividing (i) the total number of members who respond positively by (ii) the total number of members who responded to the clinical model member satisfaction question. The survey will be given to a random sample of Anthem members enrolled in a clinical	**Result** / **Penalty** 85.0% or Greater / None 83.0% to 84.9% / 50% Less than 83.0% / 100%	**Measurement Period** **Reporting Period**

		model product. This Guarantee will be based on all Anthem members; a minimum of 400 surveys must be completed within a Measurement Period for the score to be valid.		
TH Complete Timeliness of Prenatal Care	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	TH Complete Timeliness of Prenatal Care This Guarantee establishes a Quality Benchmark of 85% in the percentage of Member deliveries in which the Member had a Prenatal Care Visit (including telephone visits and online assessments) as a Member in their first trimester (Prenatal Care Rate). Anthem will be either (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 2.5% in the Prenatal Care Rate as compared to the difference between the Quality Benchmark and the Prenatal Care Rate for the Baseline Period. The Prenatal Care Rate will be calculated based on the total number of Member deliveries in which the Member had a Prenatal Care Visit (including telephone visits and online assessments) as a Member in their first trimester divided by the total number of Member deliveries. To determine the results for (i), Anthem shall compare the Prenatal Care Rate in the Measurement Period to the Quality Benchmark. The improvement percentage for (ii) will be calculated by: 1) subtracting the Prenatal Care Rate in the Baseline Period from the Prenatal Care Rate in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Prenatal Care Rate for the Baseline Period. This will be measured with Employer-specific Data.	**Result** / **Penalty** Prenatal Care Rate Improved by 2.5% or More — None OR If Prenatal Care Rate Improved by Less Than 2.5% AND is 85.0% or Greater — None 82.5% - 84.9% — 50% Less than 82.5% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly

<table>
<tr>
<td>TH Complete Avoidable ER Visit</td>
<td>Year 1: $30,000.00
Year 2: $30,000.00
Year 3: $30,000.00
Year 4: $30,000.00
Year 5: $30,000.00</td>
<td>TH Complete Avoidable ER Visit

This Guarantee establishes a Quality Benchmark of 77.5 or less avoidable Emergency Room Visits per 1,000 Members (Avoidable ER Visit Rate). Avoidable Emergency Room Visits are defined as low intensity Emergency Room Visits on the high impact diagnosis list as determined according to Anthem 's criteria. Avoidable Emergency Room Visits do not include any Emergency Room Visits that result in an Inpatient Admission.
Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be a reduction in the Avoidable ER Visit Rate for the Measurement Period compared to the Baseline Period.
Only Identified Members, for whom Anthem has at least 6 months of eligibility information in a Measurement Period, shall be considered for purposes of this Guarantee. To calculate the Avoidable ER Visit Rate, Anthem shall divide (a) the Avoidable ER Visits during the Measurement Period by (b) the number of Identified Members for such Measurement Period. In determining (b) above, Anthem shall weight the number of those Identified Members by the actual number of months that Anthem had eligibility information for those included Identified Members.
To determine the results for (i), Anthem shall compare the Avoidable ER Visit Rate to the Quality Benchmark. To determine the results for (ii), Anthem shall compare the Avoidable ER Visit Rate for the Measurement Period to the Avoidable ER Visit Rate for the Baseline Period.

This will be measured with Employer-specific Data.</td>
<td>
<table>
<tr><th>Result</th><th>Penalty</th></tr>
<tr><td>Rate is reduced</td><td>None</td></tr>
<tr><td>OR</td><td>.</td></tr>
<tr><td>If Rate is same or increases AND is</td><td>.</td></tr>
<tr><td>77.5 per 1,000 or less</td><td>None</td></tr>
<tr><td>77.6 – 80 per 1,000</td><td>50%</td></tr>
<tr><td>Greater than 80.0 per 1,000</td><td>100%</td></tr>
</table>
</td>
<td><u>Measurement Period</u>
Annual

<u>Reporting Period</u>
Quarterly</td>
</tr>
<tr>
<td>TH Complete Comprehensive Engagement</td>
<td>Year 1: $50,000.00
Year 2: $50,000.00
Year 3: $50,000.00</td>
<td>TH Complete Comprehensive Engagement
Anthem guarantees a minimum Comprehensive Engagement of 60% or a 2.5% year over year improvement in Comprehensive Engagement, including Traditional Engagement, Care Coordination Engagement, and Digital Engagement, through the use of multi-modal</td>
<td>
<table>
<tr><th>Result</th><th>Penalty</th></tr>
<tr><td>Improved by 2.5% or More</td><td>None</td></tr>
<tr><td>OR</td><td>.</td></tr>
<tr><td>If improved by Less</td><td>.</td></tr>
</table>
</td>
<td><u>Measurement Period</u>
Annual

<u>Reporting Period</u>
Quarterly</td>
</tr>
</table>

	Year 4: $50,000.00 Year 5: $50,000.00	communication channels (including mobile chat, portal click-to-chat, and bilateral text messaging), health notes, and utilization management authorizations. Traditional Engagement is defined as traditional care management telephonic engagement. Care Coordination Engagement leverages Anthem 's partnership Network Providers to coordinate a Member's care, while also encompassing the telephonic connections Members have with health guides. Digital Engagement references Member interactions through the website and mobile application, capturing communication through emails, click-to-chat discussions, bilateral text messaging and telehealth. This Guarantee requires: (i) that Employer provides email addresses for at least 60% of its eligible Subscribers and attests that Anthem may contact Members using their email addresses; (ii) that Employer provides valid phone numbers for at least 80% of its eligible Subscribers and attests that Anthem may contact Members using these phone numbers; and (iii) that Employer supports dedicated launch communication for an Anthem Digital Solution via multiple channels (e.g. email, print, intranet portals, enrollment guides) that reaches 60% of Subscribers. This will be measured with Employer-specific Data.	Than 2.5% AND is 60.0% or Greater — None 57.5% - 59.9% — 50% Less than 57.5.0% — 100%	
TH Complete High Dollar Claimant Outreach	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	TH Complete High Dollar Claimant Outreach A minimum of 90% of Identified Members who accumulate $100,000 or more of paid claims during the Measurement Period will receive successful contact from an Anthem health coach during the Measurement Period or receive at least 2 attempted outreach telephone calls within the Measurement Period from an Anthem health coach in 1 of the Anthem clinical programs. This Guarantee will include both medical and Prescription Drug claims. If Prescription Drug	**Result** — **Penalty** 90.0% or Greater — None 89.0% to 89.9% — 50% Less than 88.0% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly

<table>
<tr>
<td></td>
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<td>benefits are administered by third party payers other than Anthem , this Guarantee will include Prescription Drug claims if Prescription Drug claims data is received from Employer in a format that is acceptable to Anthem. This Guarantee does not include pediatric cases.
This Guarantee will be calculated based on the number of Identified Members who receive successful contact from an Anthem health coach during the Measurement Period or receive at least 2 attempted outreach telephone calls within the Measurement Period from an Anthem health coach divided by the number of Identified Members who accumulate $100,000 or more of paid claims in the Measurement Period.
This will be measured with Employer-specific Data.</td>
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<tr>
<td>TH Complete Inpatient Admissions</td>
<td>Year 1: $30,000.00
Year 2: $30,000.00
Year 3: $30,000.00
Year 4: $30,000.00
Year 5: $30,000.00</td>
<td>TH Complete Inpatient Admissions

This Guarantee establishes a Quality Benchmark of 65 or less Inpatient Admissions per 1,000 Members (IP Admission Rate) Inpatient Admissions are defined as admissions with Type of Service categories of Medical, Surgical and Behavioral Health. Admissions do not include admissions related to Type of Service categories of Maternity, NICU or Rehabilitation.
Anthem will either: (i) meet or exceed the benchmark; or, (ii) there will be a reduction in the IP Admission Rate from the Measurement Period compared to the Baseline Period.
Only Members, for whom Anthem has at least 6 months of eligibility information in a Measurement Period, shall be considered for purposes of this Guarantee. To calculate the IP Admission Rate, Anthem shall divide (a) the IP Admissions during the Measurement by (b) the number of Identified Members for such Measurement Period. In determining (b) above, Anthem shall weight the number of those Identified Members by the actual number of months that Anthem had eligibility information for those Identified Members.
To determine the results for (i), Anthem shall compare the IP Admission Rate to the Quality Benchmark. To determine the results for (ii),</td>
<td>
<table>
<tr><th>Result</th><th>Penalty</th></tr>
<tr><td>Local Model</td><td>.</td></tr>
<tr><td>Rate is reduced</td><td>None</td></tr>
<tr><td>OR</td><td>.</td></tr>
<tr><td>If Rate is same or Increases AND is</td><td>.</td></tr>
<tr><td>65 per 1,000 or less</td><td>None</td></tr>
<tr><td>65.1 – 70 per 1,000</td><td>50%</td></tr>
<tr><td>Greater than 70.0 per 1,000</td><td>100%</td></tr>
</table>
</td>
<td><u>Measurement Period</u>
Annual

<u>Reporting Period</u>
Quarterly</td>
</tr>
</table>

		Anthem shall compare the IP Admission Rate for the Measurement Period to the IP Admission Rate for the Baseline Period. This will be measured with Employer-specific Data.		
TH Complete Member Outreach for Pre-Admission Counseling	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	TH Complete Member Outreach for Pre-Admission Counseling A minimum of 90% of Identified Members will receive successful contact from an Anthem health coach or receive at least 2 attempted outreach telephone calls from an Anthem health coach prior to a scheduled medical or surgical admission when precertification approval as described in the Member's Benefits Booklet is completed at least 4 business days prior to the medical or surgical admission date, excluding the date of admission. This Guarantee does not include admissions related to maternity or behavioral health services. This Guarantee will be calculated based on the number of Identified Members who receive successful contact or receive at least 2 attempted outreach telephone calls prior to a scheduled medical or surgical admission divided by all Identified Members who complete the precertification process as described in the Member's Benefits Booklet at least 4 business days prior to their medical or surgical admission date, excluding the date of admission. This will be measured with Employer-specific Data.	**Result** / **Penalty** 90.0% or Greater — None 89.0% to 89.9% — 50% Less than 89.0% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly
TH Complete Member Satisfaction	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	TH Complete Member Satisfaction A minimum average score of 85% will be attained on Anthem's clinical model member satisfaction survey question. Each surveyed member is asked to rate their satisfaction with Anthem 's clinical model program using a 5 point scale. The response is scored by dividing (i) the total number of members who respond positively by (ii) the total number of members who responded to the clinical model member satisfaction question. The survey will be given to a random sample of Anthem members enrolled in a clinical	**Result** / **Penalty** 85.0% or Greater — None 83.0% to 84.9% — 50% Less than 83.0% — 100%	**Measurement Period** **Reporting Period**

		model product. This Guarantee will be based on all Anthem members; a minimum of 400 surveys must be completed within a Measurement Period for the score to be valid.		
TH Complete Timeliness of Prenatal Care	Year 1: $30,000.00 Year 2: $30,000.00 Year 3: $30,000.00 Year 4: $30,000.00 Year 5: $30,000.00	TH Complete Timeliness of Prenatal Care This Guarantee establishes a Quality Benchmark of 85% in the percentage of Member deliveries in which the Member had a Prenatal Care Visit (including telephone visits and online assessments) as a Member in their first trimester (Prenatal Care Rate). Anthem will be either (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 2.5% in the Prenatal Care Rate as compared to the difference between the Quality Benchmark and the Prenatal Care Rate for the Baseline Period. The Prenatal Care Rate will be calculated based on the total number of Member deliveries in which the Member had a Prenatal Care Visit (including telephone visits and online assessments) as a Member in their first trimester divided by the total number of Member deliveries. To determine the results for (i), Anthem shall compare the Prenatal Care Rate in the Measurement Period to the Quality Benchmark. The improvement percentage for (ii) will be calculated by: 1) subtracting the Prenatal Care Rate in the Baseline Period from the Prenatal Care Rate in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Prenatal Care Rate for the Baseline Period. This will be measured with Employer-specific Data.	**Result** / **Penalty** Prenatal Care Rate Improved by 2.5% or More — None OR If Prenatal Care Rate Improved by Less Than 2.5% AND is 85.0% or Greater — None 82.5% - 84.9% — 50% Less than 82.5% — 100%	**Measurement Period** Annual **Reporting Period** Quarterly
Dedicated Family Advocate-Engagement	Year 1: $50,000.00 Year 2: $50,000.00	A minimum of 85% of Eligible Contacts will have Member Engagement. Member Engagement is defined as coaching, education or Member direction from a Dedicated Family Advocate. This Guarantee will be calculated based on the number of Eligible Contacts with Member Engagement	**Result** / **Penalty** 85.0% or Greater — None 83.0% to 84.9% — 50% Less than 83.0% — 100%	**Measurement Period** **Annual** **Reporting Period** **Annual**

	Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	divided by the total number of contacts eligible for Member Engagement. Eligible Contacts include mobile chat, portal click-to-chat and phone contacts with a Dedicated Family Advocate. This will be measured with Employer-specific Data.		

ATTACHMENT 4
TO
SCHEDULE C

Performance Guarantees
Network Guarantees

This Attachment is made part of Schedule C and will be effective for the Performance Period of January 1, 2025 through December 31 2025. This Attachment is intended to supplement and amend the Contract between the Parties.

Network Guarantees

Performance Category	Year 1	Year 2	Year 3	Year 4	Year 5
Network Provider Discount	$750,000	N/A	N/A	N/A	N/A
Network Provider Utilization	$200,000	N/A	N/A	N/A	N/A
Provider Accessibility	$50,000	$50,000	$50,000	$50,000	$50,000
Total Amount At Risk - Network	**$1,000,000**	**$50,000**	**$50,000**	**$50,000**	**$50,000**

Additional Terms and Conditions

a. This/These Guarantee(s) applies to following time periods:(Measurement Period)

- Year 1: Claims Incurred from January 01, 2025 through December 31, 2025 and Paid from January 01, 2025 and through March 31, 2026.
- Year 2: Claims Incurred from January 01, 2026 through December 31, 2026 and Paid from January 01, 2026 and through March 31, 2027.
- Year 3: Claims Incurred from January 01, 2027 through December 31, 2027 and Paid from January 01, 2027 and through March 31, 2028.
- Year 4: Claims Incurred from January 01, 2028 through December 31, 2028 and Paid from January 01, 2028 and through March 31, 2029.
- Year 5: Claims Incurred from January 01, 2029 through December 31, 2029 and Paid from January 01, 2029 and through March 31, 2030

b. This Guarantee excludes all charges for any Member whose allowed Claims exceed $250,000.00 during the Measurement Period.

c. Anthem has the right in its sole discretion to modify or terminate this Guarantee if any of these occur:

d. Anthem is no longer the sole administrator for Employer's Plan.

e. Employer fails to maintain at least an average enrollment of 33000 Subscribers.

f. The geographic distribution of Subscribers changes by more than 5% in any state or by more than 10 subscribers in such state, whichever is greater.

g. Total subscriber enrollment changes by more than 15% from the Employer census provided for purposes of establishing this Guarantee.

h. A change is initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Network Provider Discount	Year 1: $750,000.00	Anthem guarantees a minimum Network Provider Discount of 61.300%. This Guarantee excludes all charges for any Member whose allowed Claims exceed $250,000.00 during the Measurement Period. Eligible Claim Charges are defined as charges for Covered Services provided to Members enrolled in PPO EPO POS Plans. Eligible Claim Charges will be based on Anthem primary Claims only and will not include charges related to Prescription Drug Claims, Inter-Plan Program fees, state surcharges, Anthem Provider payment innovation programs or services rendered outside the United States. Allowed Amount is defined as the amount paid by Anthem to PPO EPO POS Network Providers on Eligible Claim Charges plus any Member cost shares. This Guarantee will be calculated by dividing the PPO EPO POS Network Provider Allowed Amounts by the PPO EPO POS Network Eligible Claim Charges. The resulting percentage shall be subtracted from 100% to determine the Network Provider Discount. Anthem reserves the right to re-evaluate the guaranteed discount if the actual combined in-network service mix is not within 3 percentage points of any one or more of the following: 18.100% inpatient hospital, 49.400% outpatient hospital and 32.500% professional. Only Claims submitted to a Blue Cross and/or Blue Shield licensee for processing and adjudication shall be considered for purposes of this Discount Guarantee. This Guarantee assumes that, per the uniform data standard specifications released on 02/24/2022, Provider billed charge trend will be as follows: 4% inpatient hospital, 6.5% outpatient hospital and 4% professional. This Guarantee is subject to modification if actual billed charge trend falls below these amounts. This will be measured with Employer-specific Data.	**Result** / **Penalty** If Actual Results are lower than the final Guarantee by: 0.0% to 1.0% — None 1.1% to 2.0% — 50% More than 2.0% — 100%	**Measurement Period** Annual-This period applies to Claims incurred from January 01, 2025 through December 31, 2025 and Paid from January 01, 2025 and through March 31, 2026 **Reporting Period** Annual
Network Provider Utilization	Year 1: $200,000.00	A minimum of 98.200% of Eligible Claim Charges will be for services provided by	**Result** / **Penalty**	**Measurement Period**

		Providers payable at the in-Network level of benefits. Eligible Claim Charges are defined as charges for Covered Services provided to Members enrolled in PPO EPO POS Plans. Eligible Claim Charges will be based on Anthem primary Claims only and will not include charges related to Prescription Drug Claims, Inter-Plan Program fees, state surcharges, or Claims incurred outside the United States, Puerto Rico and US Virgin Islands. This Guarantee will be calculated by dividing the total Eligible Claim Charges payable at the in-Network level of benefits by the total Eligible Claim Charges. The total Eligible Claim Charges payable at the in-Network level of benefits may not include certain charges related to out of Network providers that are reimbursed at the in-Network level of benefits. This Guarantee excludes all charges for any Member whose allowed Claims exceed 250,000.00 during the Measurement Period. This will be measured with Employer-specific Data.	If Actual Results are lower than the final Guarantee by: 0 to 1.0% None 1.1% to 2.0% 50% More than 2.1% 100%	Annual-This period applies to Claims incurred from January 01, 2025 through December 31, 2025 and Paid from January 01, 2025 and through March 31, 2026 **Reporting Period** Annual
Provider Accessibility	Year 1: $50,000.00 Year 2: $50,000.00 Year 3: $50,000.00 Year 4: $50,000.00 Year 5: $50,000.00	There will be a 5% or less change in member access to network providers. Member Access will be established by running a GeoAccess report prior to the beginning of each Measurement Period. Member Access is defined as access to: (i) at least 1 primary care Provider in the following geographic areas: Urban: 10 miles Basic: 20 miles Rural: 30 miles; and (ii) at least 1 specialist Provider for chiropractic, general surgery, and OB/GYN in the following geographic areas: Urban: 15 miles Basic: 30 miles Rural: 60 miles; and (iii) at least 1 basic hospital in the following geographic areas: Urban: 30 miles Basic: 30 miles Rural: 30 miles; and (iv) at least 1 tertiary hospital in the following geographic areas: Urban: 100 miles	**Result** **Penalty** Less than 5.0% None 5.1% to 5.5% 50% Greater than 5.5% 100%	**Measurement Period** Annual **Reporting Period** Annual

		Basic: 100 miles Rural: 100 miles This guarantee will be calculated based on the results of a GeoAccess report run at the beginning of a Measurement Period compared to the results of a GeoAccess report run at the end of a Measurement Period. This guarantee will not include vision, dental or pharmacy providers. This will be measured with Employer-specific Data.		

SCHEDULE D

INTER-PLAN ARRANGEMENTS SCHEDULE
TO
CONTACT # 25-01012025

This Inter-Plan Arrangement Schedule supplements and amends the Contract and is effective as of January 1, 2025. In the event of an inconsistency between the applicable provisions of this Schedule, any other Schedule and/or the Contract, the terms of this Schedule shall govern, but only as they relate to the Inter-Plan Arrangements. Except as set forth herein, all other terms and conditions of the Contract remain in full force and effect.

Out-of-Area Services

Overview

TPA has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements operate under rules and procedures issued by BCBSA. Whenever Members access healthcare services outside the geographic area TPA serves (the "TPA Service Area"), the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the TPA Service Area, Members obtain care from healthcare Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. TPA remains responsible for fulfilling its contractual obligations to MCHCP. TPA's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that dental care, Prescription Drug or vision benefits may not be processed through Inter-Plan Arrangements.

If the Plan covers only limited healthcare services received outside of TPA's Service Area, services other than those listed as Covered Services (e.g., emergency services) in the Plan will not be covered when processed through any Inter-Plan Arrangements, unless authorized by TPA. Providers providing such non-Covered Services will be considered Non-Participating Providers.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the TPA Service Area, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim

a. Member Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Member liability on Claims for Covered Services will be based on the lower of the Participating Provider's Billed Charges or the negotiated price made available to TPA by the Host Blue.

a. MCHCP Liability Calculation

The calculation of MCHCP liability on Claims for Covered Services will be based on the negotiated price made available to TPA by the Host Blue. Sometimes, this negotiated price may be greater for a given service or services than the Billed Charges in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds

the Billed Charges, MCHCP may be liable for the excess amount even when the Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Participating Provider, even when the contracted price is greater than the Billed Charges.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Participating Provider contracts. The negotiated price made available to TPA by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of Billed Charges in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Participating Providers or a similar classification of its Participating Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price MCHCP pays on a specific Claim and the actual amount the Host Blue pays to the Participating Provider. However, the BlueCard Program requires that the amount paid be a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to MCHCP will be adjusted in a following year, as necessary, to account for over- or under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from MCHCP. Upon termination, MCHCP will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

B. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, TPA may process Claims for Covered Services through negotiated arrangements. A negotiated arrangement is an agreement negotiated between TPA and one or more Host Blues for any group health plan that is not delivered through the BlueCard Program ("Negotiated Arrangement").

In addition, if TPA and MCHCP agree that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in TPA's Negotiated Arrangement(s) with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Members access such network(s). In negotiating such arrangement(s), TPA is not acting on behalf of or as an agent for MCHCP, the Plan or Members.

Member Liability Calculation

If TPA has entered into a Negotiated Arrangement with a Host Blue, the calculation of Member cost-sharing will be based on the lower of either Billed Charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to TPA and that allows Members access to negotiated participation agreement networks of specified Participating Providers outside of TPA's service area.

C. Special Cases: Value-Based Programs

Definitions

1. **Accountable Care Organization (ACO):** A group of Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.
2. **Care Coordination:** Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
3. **Care Coordinator:** An individual within a Provider organization who facilitates Care Coordination for patients.
4. **Care Coordinator Fee:** A fixed amount paid by a Host Plan to Providers periodically for Care Coordination under a Value-Based Program.
5. **Global Payment/Total Cost of Care:** A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient, such as outpatient, physician, ancillary, hospital services, and prescription drugs.
6. **Patient-Centered Medical Home (PCMH):** A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.
7. **Provider Incentive:** An additional amount of compensation paid to a Provider by a Host Blue, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.
8. **Shared Savings:** A payment mechanism in which the Provider and the payer share cost savings achieved against a target cost budget based on agreed upon terms and may include downside risk.
9. **Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Value-Based Programs Overview

Members may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to TPA, which TPA will pass directly on to MCHCP as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to MCHCP via an enhanced Provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor

may be adjusted from time to time. This pricing method may be used only for non-attributed Value-Based Programs.

When such amounts are billed separately from the price of the Claim, they may be billed using a Per Member Per Month billing for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. TPA will pass these Host Blue charges directly through to MCHCP as a separately identified amount on the MCHCP billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.

- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If the Agreement terminates, MCHCP will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Members will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

Host Blues may also bill TPA for Care Coordinator Fees for Provider services which TPA will pass on to MCHCP as follows:

1. PMPM billings; or

2. Individual Claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

TPA and MCHCP will not impose Member cost-sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If TPA has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, TPA will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted above.

D. Non-Participating Providers Outside TPA's Service Area

1. Allowed Amounts and Member Liability Calculation

Unless otherwise described in the Plan, when Covered Services are provided outside of TPA's Service Area by Non-Participating Providers, TPA may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount the Member pays for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment TPA will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, which may occur at MCHCP's direction, TPA may use other pricing methods, such as Billed Charges, the pricing TPA would use if the healthcare services had been obtained within TPA's Service Area, or a special negotiated price to determine the amount TPA will pay for services provided by Non-Participating Providers. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Provider bills and the payment TPA makes for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core®

General Information

If Members are outside the United States (hereinafter, "BlueCard Service Area"), they may be able to take advantage of Blue Cross Blue Shield Global Core® when accessing Covered Services. The Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard Service Area, Members will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Member paid in full at the time of service, the Member must submit a Claim to obtain reimbursement for Covered Services. Members must contact TPA to obtain precertification for non-emergency inpatient services.

Outpatient Services

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard Service Area will typically require Members to pay in full at the time of service. Members must submit a Claim to obtain reimbursement for Covered Services.

F. Recoveries

Host Blues may conduct: (i) prepayment review activities including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits and (ii) recoveries of overpayments including, but not limited to, anti-fraud and abuse reviews, audits/healthcare Provider/hospital bill audits, credit balance audits, and utilization review refunds (collectively, for (i) and (ii), "Recoveries"). Recoveries will be applied, in general, on either a Claim-by-Claim or prospective basis. If Recoveries are passed on a Claim-by-Claim basis from a Host Blue to TPA, they will be credited to MCHCP. In some cases, the Host Blue will engage a third party to assist in identification related to Recoveries, including collection of overpayments. MCHCP may be charged a fee for Recoveries as described in Schedule A.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, TPA will request the Host Blue to provide full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, and Care Coordination Fees or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this Agreement.

G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees or compensation are generally made effective January 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes resulting in an increase in fees paid by MCHCP, TPA shall provide MCHCP with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and MCHCP right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If MCHCP fails to respond to the notice and does not terminate this Agreement during the notice period, MCHCP will be deemed to have approved the proposed changes, and TPA will then allow such modifications to become part of this Agreement.

H. Fees and Compensation

MCHCP understands and agrees to reimburse TPA for certain fees and compensation which TPA is obligated under the applicable Inter-Plan Arrangements described in this Schedule to pay to the Host Blues, to BCBSA and/or to vendors of Inter-Plan Arrangement-related services. The specific Inter-Plan Arrangement fees and compensation, including any administrative and/or network access fee that a Host Blue may charge under the BlueCard Program, a Negotiated Arrangement, and Blue Cross Blue Shield Global Core are charged to MCHCP are set forth in Section 7 of Schedule A to the Contract. The various Inter-Plan Arrangement Fees and compensation may be revised from time to time as described in section G.

A description of the various Claim processing fees that may be listed on Schedule A is as follows:

Access Fee: The Access Fee is charged by the Host Blue to TPA for making its applicable Provider network available to Members. The Access Fee will not apply to Non-Participating Provider Claims. The Access Fee is charged on a per Claim basis and is charged as a percentage of the discount/differential TPA receives from the applicable Host Blue subject to a maximum of $2,000 per Claim. When charged, TPA passes the Access Fee directly on to MCHCP.

Instances may occur in which the Claim payment is zero or TPA pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, TPA will pay the Host Blue's Access Fee and pass it along directly to MCHCP as stated above even though MCHCP paid little or had no Claim liability.

Administrative Expense Allowance (AEA) Fee: The AEA Fee is a fixed per Claim dollar amount charged by the Host Blue to TPA for administrative services the Host Blue provides in processing Claims for MCHCP's Members. The dollar amount is normally based on the type of Claim (e.g. institutional, professional, international, etc.) and can also be based on the size of group enrollment. When charged, TPA passes the AEA Fee directly on to MCHCP.

Per Subscriber Per Month (PSPM) Fee: The PSPM Fee is a financial arrangement negotiated between the Host Blue and TPA and replaces all other fees, including the Access Fee and AEA Fee. The PSPM dollar amount is charged on a per Subscriber per month basis by the Host Blue to TPA for administrative services the Host Blue provides in processing Claims for MCHCP's Members. The dollar amount can also be based on the size of group enrollment. When charged, TPA passes the PSPM Fee directly on to MCHCP.

Non-Standard AEA Fee: The Non-Standard AEA Fee is a financial arrangement negotiated between the Host Blue and TPA and replaces all other fees, including the Access Fee and AEA Fee. The Non-Standard AEA is a fixed per Claim dollar amount charged by the Host Blue to TPA for administrative services the Host Blue provides in processing Claims for MCHCP's Members. When charged, TPA passes the Non-Standard AEA Fee directly on to MCHCP.

Central Financial Agency (CFA) Fee: The CFA Fee is a fixed dollar amount per payment notice and is paid by TPA to the BCBSA. This fee applies each time TPA receives an electronic payment notice from the CFA indicating that a Host Blue incurred Claim-related liability on TPA's behalf and requesting that TPA either approve or deny payment. When charged, TPA passes the CFA Fee directly on to MCHCP. The CFA Fee supports ongoing operations of BCBSA programs and services, including but not limited to Blue Cross Blue Shield AXIS® Data Services, network solutions, and BlueCard Program-related applications.

Inter-Plan Teleprocessing System (ITS) Transaction Fee: The ITS delivery platform allows all Blue Cross and/or Blue Shield Licensees to connect with each other through a standardized system to facilitate the operation of Inter-Plan Arrangements. The ITS Transaction Fee applies each time a Claims transaction interchange occurs between TPA and a Host Blue. When a Host Blue receives a Claim, it applies Provider pricing information, sets forth its discount and related savings and sends this information to TPA electronically. TPA then adjudicates the Claim, computes the approved Provider payment amount, calculates the AEA Fee and Access Fee, computes net liability and sends a response electronically to the Host Blue. The Host Blue then pays the Provider and issues an electronic payment notice

to TPA via the CFA. The ITS Transaction Fee is five cents per interchange and is paid to the BCBSA. For each Claim, there are a minimum of three interchanges, but there could be more depending on the complexity of the Claim. When charged, TPA passes the ITS Transaction Fee directly on to MCHCP.

Schedule E
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") between the Missouri Consolidated Health Care Plan (hereinafter "Covered Entity" or "MCHCP") and TPA. (hereinafter "Business Associate") is entered into as a result of the business relationship between the parties in connection with services requested and performed in accordance with the MCHCP's 2024 Health Plan ("RFP") and under Contract *#25-010125-TPA*, as renewed and amended, (hereinafter the "Contract").

This Agreement supersedes all other agreements, including any previous business associate agreements, between the parties with respect to the specific matters addressed herein. In the event the terms of this Agreement are contrary to or inconsistent with any provisions of the Contract or any other agreements between the parties, this Agreement shall prevail, subject in all respects to the Health Insurance Portability and Accountability Act of 1996, as amended (the "Act"), and the HIPAA Rules, as defined in Section 2.1 below.

1 Purpose.

The Contract is for third party administrative services for MCHCP's self-funded employee benefit plans for State and Public Entity members.

The purpose of this Agreement is to comply with requirements of the Act and the implementing regulations enacted under the Act, 45 CFR Parts 160 - 164, as amended, to the extent such laws relate to the obligations of business associates, and to the extent such laws relate to obligations of MCHCP in connection with services performed by TPA for or on behalf of MCHCP under the Contract. This Agreement is required to allow the parties to lawfully perform their respective duties and maintain the business relationship described in the Contract.

2 Definitions.

For purposes of this Agreement: "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to this Agreement, shall mean TPA.

"Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to this Agreement, shall mean MCHCP.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules set forth in 45 CFR Parts 160 and 164, as amended.

2.1 Unless otherwise expressly stated in this Agreement, all words, terms, specifications, and requirements used or referenced in this Agreement which are defined in the HIPAA Rules shall have the same meanings as described in the HIPAA Rules, including but not limited to: breach; data aggregation; designated record set; disclose or disclosure; electronic media; electronic protected health information ("ePHI"); family member; genetic information; health care; health information; health care operations; individual; individually identifiable health information; marketing; minimum necessary; notice of privacy practices; person; protected health information ("PHI"); required by law; Secretary; security incident; standard; subcontractor; transaction; unsecured PHI; use; violation or violate; and workforce.

2.2 To the extent a term is defined in the Contract and this Agreement, the definition in this Agreement, subject in all material respects to the HIPAA Rules, shall govern.

2.3 Notwithstanding the forgoing, for ease of reference throughout this Agreement, Business Associate understands and agrees that wherever PHI is referenced in this Agreement, it shall be deemed to include all MCHCP-related PHI in any format or media including paper, recordings, electronic media, emails, and all forms of MCHCP-related ePHI in any data state, be it data in motion, data at rest, data in use, or otherwise.

3 Obligations and Activities of Business Associate.

3.1 Business Associate agrees to not use or disclose PHI other than (1) as permitted or required by this Agreement or any other agreement between the parties, (2) as permitted in writing by the Plan or its Plan administrator, (3) as authorized by Individuals, (4) or as required by law.

3.2 Appropriate Safeguards. Business Associate agrees to implement, maintain, and use appropriate administrative, physical, and technical safeguards, and fully comply with all applicable standards, implementation specifications, and requirements of Subpart C of 45 CFR Part 164 with respect to ePHI, in order to: (i) ensure the confidentiality, integrity, and availability of ePHI created, received, maintained, or transmitted; (ii) protect against any reasonably anticipated threats or hazards to the security or integrity of such information; and (iii) protect against use or disclosure of ePHI by Business Associate, its workforce, and its subcontractors other than as provided for by this Agreement.

3.3 Subcontractors. Pursuant to §§ 164.308(b)(2) and 164.502(e)(1)(ii), Business Associate agrees it will not permit any subcontractors to create, receive, access, use, maintain, disclose, or transmit PHI in connection with, on behalf of, or under the direction of Business Associate in connection with performing its duties and obligations under the Contract unless and until Business Associate obtains satisfactory assurances in the form of a written contract or written agreement in accordance with §§ 164.504(e) and 164.314(a)(2) that the subcontractor(s) will appropriately safeguard PHI and in all respects comply with essentially similar restrictions, conditions, and requirements applicable to Business Associate under the HIPAA Rules and this Agreement with respect to such information.

In addition to the forgoing, and in accordance with the Contract, Business Associate agrees it will not permit any subcontractor, or use any off-shore entity, to perform services under the Contract, including creation, use, storage, or transmission of PHI at any location(s) outside of the United States.

3.4 Reports to MCHCP. Business Associate agrees to report any use or disclosure of PHI not authorized or provided for by this Agreement, including breaches of unsecured PHI and any security incident involving MCHCP to MCHCP in accordance with the notice provisions prescribed in this Section 3.4. Such report shall not include instances where Business Associate inadvertently misroutes PHI to a provider to the extent the disclosure is not a Breach as defined under 45 CFR §164.402. For purposes of the security incident reporting requirement, the term "security incident" shall not include inconsequential incidents that occur on a daily basis, such as scans, "pings," or other unsuccessful attempts to penetrate computer networks or servers containing ePHI maintained or transmitted by Business Associate.

3.4.1 The notice shall be delivered to, and confirmed received by, MCHCP promptly and without unreasonable delay, but in any event no later than fifteen (15) business days of Business Associate's first discovery, as discovery is described under § 164.410, of the unauthorized use or disclosure, breach of unsecured PHI, or security incident.

3.4.2 The notice shall be in writing and sent to both of the following MCHCP workforce members and deemed delivered only upon personal confirmation, acknowledgement or receipt in any form, verbal or written, from one of the designated recipients:

- MCHCP's Privacy Officer → currently, Jennifer Stilabower, (573) 522-3242, Jennifer.Stilabower@mchcp.org, 832 Weathered Rock Court, Jefferson City, MO 65101

- MCHCP's Security Officer → currently, Brad Kifer, (573) 526-2858, Brad.kifer@mchcp.org, 832 Weathered Rock Court, Jefferson City, MO 65101

If, and only if, Business Associate receives an email or voicemail response indicating neither of the intended MCHCP recipients are available and no designee(s) confirm receipt within eight (8) business hours on behalf of one or both of the above-named MCHCP Officers, Business Associate shall forward the written notice to their primary MCHCP contact with copies to the Privacy and Security Officers for documentation purposes.

3.4.3 The notice shall include to the extent possible:

a) a detailed description of what happened, including the date, time, and all facts and circumstances surrounding the unauthorized use or disclosure, breach of unsecured PHI, or security incident;

b) the date, time, and circumstances surrounding when and how Business Associate first became aware of the unauthorized use or disclosure, breach of unsecured PHI, or security incident;

c) identification of each individual whose PHI has been, or is reasonably believed by Business Associate to have been involved or otherwise subject to possible breach;

d) a description of all types of PHI known or potentially believed to be involved or affected;

e) identification of any and all unauthorized person(s) who had access to or used the PHI or to whom an unauthorized disclosure was made;

f) all decisions and steps Business Associate has taken to date to investigate, assess risk, and mitigate harm to MCHCP and all potentially affected individuals;

g) contact information, including name, position or title, phone number, email address, and physical work location of the individual(s) designated by Business Associate to act as MCHCP's primary contact for purposes of the notice triggering event(s);

h) all corrective action steps Business Associate has taken or shall take to prevent future similar uses, disclosures, breaches, or incidents;

i) if all investigatory, assessment, mitigation, or corrective action steps are not complete as of the date of the notice, Business Associate's best estimated timeframes for completing each planned but unfinished action step; and

j) any action steps Business Associate believes affected or potentially affected individuals should take to protect themselves from potential harm resulting from the matter.

3.4.4 Business Associate agrees to cooperate with MCHCP during the course of Business Associate's investigation and risk assessment and to promptly and regularly update MCHCP in writing as supplemental information becomes available relating to any of the items addressed in the notice.

3.4.5 Business Associate further agrees to provide additional information upon and as reasonably requested by MCHCP; and to take any additional steps MCHCP reasonably deems necessary or advisable to comply with MCHCP's obligations as a covered entity under the HIPAA Rules.

3.4.6 Business Associate expressly acknowledges the presumption of breach with respect to any unauthorized acquisition, access, use, or disclosure of PHI, unless Business Associate is able to demonstrate otherwise in accordance with § 164.402(2), in which case, Business Associate agrees to conduct and fully document its assessment and all factors considered and provide MCHCP, with its conclusion reached, in the notice provided to MCHCP.

3.4.7 In addition to providing notice to Plan of a Breach, Business Associate will provide any required notice to individuals and applicable regulators on behalf of Plan.

3.4.8 Business Associate agrees to bear all reasonable and actual costs associated with its notifications, publications, or public reports relating to breaches by Business Associate, any subcontractor of

Business Associate, and any employee or workforce member of Business Associate and/or its subcontractors,

3.5 Confidential Communications. Business Associate will respond to an Individual's request for a confidential communication as part of Business Associate's normal customer service function, or such requests made by the Plan on behalf of an Individual. Business Associate will respond to such requests with respect to the PHI Business Associate and its subcontractors maintain in manner and timeframe consistent with requirements specified in the HIPAA Regulations. If an individual's request extends beyond information held by Business Associate and Business Associate's subcontractors, Business Associate will inform the Individual to direct the request to the Plan, or the Plan directly, so that Plan may coordinate the request. Business Associate assumes no obligation to coordinate any request for a confidential communication of PHI maintain by other business associate of Plan. Upon receipt of written notice from the Plan, Business Associate agrees it will implement and honor individual requests to receive PHI by alternative means or at an alternative location provided such request has been directed to and approved by MCHCP in accordance with § 164.522(b).

3.6 Individual Access to PHI. If an individual requests access to PHI under § 164.524, Business Associate agrees it will make all PHI about the individual which Business Associate created or received for or from MCHCP that is in Business Associate's custody or control available in a designated record set to MCHCP or, at MCHCP's direction, to the requesting individual or his or her authorized designee, in order to satisfy MCHCP's obligations as follows:

3.6.1 If Business Associate receives a request for individual PHI in a designated record set from MCHCP, Business Associate will provide the requested information to MCHCP within a timeframe and manner consistent with 45 C.F.R. § 164.524 from the date of the request in a readily accessible and readable form and manner or as otherwise reasonably specified in the request.

3.6.2 If Business Associate receives a written request for PHI in a designated record set directly from an individual current or former MCHCP member, Business Associate will require that the request be made in writing.If the individual submits a written request for PHI in a designated record set directly to Business Associate, Business Associate will respond to the request with respect to the PHI Business Associate and its subcontractors maintain within a timeframe and manner consistent with 45 C.F.R. § 164.524, , Business Associate agrees to provide the designated record set requested in the form and format requested by the individual if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by Business Associate and the individual.

3.7 Amendments of PHI. Business Associate agrees it will make any amendment(s) to PHI in a designated record set pursuant to § 164.526, and take other measures as necessary and reasonably requested by MCHCP to satisfy MCHCP's obligations under § 164.526.

3.7.1 If Business Associate receives a request directly from an individual to amend PHI created by Business Associate, received from MCHCP, or otherwise within the custody or control of Business Associate at the time of the request, Business Associate shall respond to the Individual's request to amend his or her PHI with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with the requirements specified in section 45 C.F.R. § 164.526.

3.7.2 MCHCP will direct Business Associate in writing as to any actions Business Associate is required to take with regard to amending records of individuals who exercise their right to amend PHI under the HIPAA Rules. Business Associate agrees to follow the direction of MCHCP regarding such amendments and to provide written confirmation of such action in a timeframe consistent with section 45 C.F.R. § 164.526after receipt of MCHCP's written direction.

3.8 PHI Disclosure Accounting. Business Associate agrees to document, maintain, and make available to MCHCP within a time frame and manner consistent with requirements specified in § 164.528 after receipt of a request from MCHCP for all disclosures made by or under the control of Business Associate or its

subcontractors that are subject to accounting, including all information required, under § 164.528 to satisfy MCHCP's obligations regarding accounting of disclosures of PHI.

3.8.1 If Business Associate receives a request for accounting directly from an individual, Business Associate will respond to the individual's request for an accounting of disclosures of his or her PHI with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in § 164.528.

3.8.2 In addition to the provisions of 3.8.1, all PHI accounting requests received by Business Associate directly from the individual shall be acted upon by Business Associate as a request from MCHCP for purposes of Business Associate's obligations under this section. Business Associate shall provide all accounting information subject to disclosure under § 164.528 to MCHCP.

3.9 Privacy of PHI. Business Associate agrees to fully comply with all provisions of Subpart E of 45 CFR Part 164 that apply to MCHCP to the extent Business Associate has agreed or assumed responsibilities under the Contract or this Agreement to carry out one or more of MCHCP's obligation(s) under 45 CFR Part 164 Subpart E.

3.10 Internal Practices, Books, and Records. Upon request of MCHCP or the Secretary, Business Associate will make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of MCHCP available to the Secretary for purposes of determining MCHCP's and/or Business Associate's compliance with the HIPAA Rules.

4 Permitted Uses and Disclosures of PHI by Business Associate.

4.1 Contractual Authorization. Business Associate may access, create, use, and disclose PHI as necessary to perform its duties and obligations required by the Contract, including but not limited to specific requirements set forth in the Scope of Work (as such term is defined in the Contract), as amended. Without limiting the foregoing general authorization, MCHCP specifically authorizes Business Associate to access, create, receive, use, and disclose all PHI which is required to provide the services specified in the Contract. The parties agree that no provision of the Contract permits Business Associate to use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if used or disclosed in like manner by MCHCP except that:

4.1.1 This Agreement permits Business Associate to use PHI received in its capacity as a business associate of MCHCP, if necessary: (A) for the proper management and administration of Business Associate; or (B) to carry out the legal responsibilities of Business Associate.

4.1.2 This Agreement permits Business Associate to use PHI to combine PHI created or received on behalf of MCHCP as authorized in this Agreement with PHI lawfully created or received by Business Associate in its capacity as a business associate of other covered entities to permit data aggregation services, and to create De-identified PHI, Summary Health Information and/or Limited Data Sets. Business Associate is expressly permitted to disclose PHI to Health Care Providers as permitted by the HIPAA Regulations.

4.2 Authorization by Law. Business Associate may use or disclose PHI as permitted or required by law.

4.3 Minimum Necessary. Notwithstanding any other provision in the Contract or this Agreement, with respect to any and all uses and disclosures permitted, Business Associate agrees to request, create, access, use, disclose, and transmit PHI involving MCHCP members subject to the following minimum necessary requirements:

4.3.1 When requesting or using PHI received from MCHCP, a member of MCHCP, or an authorized party or entity working on behalf of MCHCP, Business Associate shall make reasonable efforts to limit all requests and uses of PHI to the minimum necessary to accomplish the intended purpose of the request or use. Business Associate agrees its reasonable efforts will include identifying those

persons or classes of persons, as appropriate, in Business Associate's workforce who need access to MCHCP member PHI to carry out their duties under the Contract. Business Associate further agrees to identify the minimally necessary amount of PHI needed by each such person or class and any conditions appropriate to restrict access in accordance with such assessment.

4.3.2 For any type of authorized disclosure of PHI that Business Associate makes on a routine basis to third parties, Business Associate shall implement procedures that limit the PHI disclosed to the amount minimally necessary to achieve the purpose of the disclosure. For all other authorized but non-routine disclosures, Business Associate shall develop and follow criteria for reviewing requests and limiting disclosures to the information minimally necessary to accomplish the purposes for which disclosure is sought.

4.3.3 Business Associate may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose if and when:

a) Making disclosures to public officials as permitted under § 164.512, if the public official represents that the information requested is the minimum necessary for the stated purpose(s); or

b) The information is requested by a professional who is a member of its workforce or is a business associate of MCHCP for the purpose of providing professional services to MCHCP, if the professional represents that the information requested is the minimum necessary for the stated purpose(s).

4.3.4 Minimum necessary does not apply to: uses or disclosures made to the individual; uses or disclosures made pursuant to a HIPAA-compliant authorization; disclosures made to the Secretary in accordance with the HIPAA Rules: disclosures specifically permitted or required under, and made in accordance with, the HIPAA Rules.

5 Obligations of MCHCP.

5.1 Notice of Privacy Practices. MCHCP shall notify Business Associate of any limitation(s) that may affect Business Associate's use or disclosure of PHI by providing Business Associate with MCHCP's Notice of Privacy Practices in accordance with § 164.520, the most recent copy of which is attached to this Agreement.

5.2 Individual Authorization Changes. MCHCP shall notify Business Associate in writing of any changes in, or revocation of, the authorization by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.3 Confidential Communications. MCHCP shall notify Business Associate in writing of individual requests approved by MCHCP in accordance with § 164.522 to receive communications of PHI from Business Associate by alternate means or at alternative locations, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.4 Individual Restrictions. MCHCP shall notify Business Associate in writing of any restriction to the use or disclosure of PHI that MCHCP has agreed and, if applicable, any subsequent revocation or termination of such restriction, in accordance with § 164.522, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.5 Permissible Requests by MCHCP. MCHCP shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by MCHCP.

6 Term and Termination, Expiration, or Cancellation.

6.1 Term. This Agreement is effective upon signature of both parties, and shall terminate upon the termination, expiration, or cancellation of the Contract, as amended, unless sooner terminated for cause under subsection 6.2 below.

6.2 Termination. Without limiting the parties right to terminate the Contract in accordance with the terms therein, each party may also terminate this Agreement immediately by written notice and without penalty if such party determines, in its sole discretion, that the other party has engaged in a pattern of activity or practice that constitutes a material term of this Agreement Without limiting the foregoing authorization, the parties agrees that, as an alternative or in addition to termination, the non-breaching party require to the breaching party to end the violation and cure the breach within the time and manner specified by the non-breaching party, based on the circumstances presented. With respect to this subsection, the parties remedies under this Agreement and the Contract are cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

6.3 Obligations of Business Associate Upon Termination. Upon termination, expiration, or cancellation of this Agreement for any reason, the parties agrees that the destruction or return of PHI by Business Associate is not feasible given the regulatory requirements to maintain and produce such information for extended periods of time after such termination. In addition, Business Associate is required to maintain such records to support its contractual obligations with its vendors and network providers and, as applicable, maintain Individuals treatment records.

Business Associate may maintain MCHCP-PHI after the termination of this Agreement to the extent return or destruction of the PHI is not feasible, provided Business Associate: (i) limits any further use or disclosure of the PHI; (ii) continues to safeguard the PHI thereafter in accordance with the terms of this Agreement, for so long as Business Associate, or its subcontractors or agents, maintains such PHI. Business Associate may destroy such PHI in accordance with applicable law and its retention policy that it applies to similar records.

6.4 Survival. All obligations and representations of Business Associate under this Section 6 and subsection 7.2 shall survive termination, expiration, or cancellation of the Contract and this Agreement.

7 Miscellaneous.

7.1 Satisfactory Assurance. Business Associate expressly acknowledges and represents that execution of this Agreement is intended to, and does, constitute satisfactory assurance to MCHCP of Business Associate's full and complete compliance with its obligations under the HIPAA Rules. Business Associate further acknowledges that MCHCP is relying on this assurance in permitting Business Associate to create, receive, maintain, use, disclose, or transmit PHI as described herein.

7.2 Indemnification. The parties agree that the indemnification provision of the administrative services Contract between the parties shall apply in the same manner and with the same force and effect on the parties' duties and obligations under this Agreement as to the Contract.

7.3 No Third Party Beneficiaries. There is no intent by either party to create or establish third party beneficiary status or rights or their equivalent in any person or entity, other than the parties hereto, that may be affected by the operation of this Agreement, and no person or entity, other than the parties, shall have the right to enforce any right, claim, or benefit created or established under this Agreement.

7.4 Amendment. The parties agree to work together in good faith to amend this Agreement from time to time as is necessary or advisable for compliance with the requirements of the HIPAA Rules. Notwithstanding the foregoing, this Agreement shall be deemed amended automatically to the extent any provisions of the Act or the HIPAA Rules not addressed herein become applicable to Business Associate during the term of this Agreement pursuant to and in accordance with any subsequent modification(s) or official and binding legal clarification(s), to the Act or the HIPAA Rules.

7.5 Interpretation. Any reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

THE UNDERSIGNED PERSONS REPRESENT AND WARRANT THAT WE ARE LEGALLY FREE TO ENTER THIS AGREEMENT, THAT OUR EXECUTION OF THIS AGREEMENT HAS BEEN DULY AUTHORIZED, AND THAT UPON BOTH OF OUR SIGNATURES BELOW THIS SHALL BE A BINDING AGREEMENT TO THE FOREGOING TERMS AND CONDITIONS OF THIS BUSINESS ASSOCIATE AGREEMENT.

Missouri Consolidated Health Care Plan

By: _____

Title: Executive Director

Date: 10/01/2024

TPA

By: _____

Title: President

Date: 8/27/24

SCHEDULE F
INFORMATION SECURITY SCHEDULE
TO
CONTRACT # 25-01012025

This Information Security Schedule supplements and amends the Contract and is effective as of January 1, 2025. In the event of an inconsistency between the applicable provisions of this Schedule, any other Schedule and/or the Contract, the terms of this Schedule shall govern, but only as they relate to information security. Except as set forth herein, all other terms and conditions of the Contract remain in full force and effect.

1. Definitions. The definitions noted below shall apply for purposes of this Information Security Schedule.

   a) "Covered Information" means Protected Health Information, as defined under the Parties' Business Associate Agreement (BAA) and Personal Information, as defined under applicable state data breach notification laws.

   b) "Information System" means an interconnected set of information resources and includes hardware, software, databases, and applications that collect, process, store, transmit, display, disseminate, and act on Covered Information.

2. Written Information Security Program. TPA represents that it has established, and shall maintain for the duration of this Agreement, a written information security program that addresses the management of security and the controls employed within the organization to protect the confidentiality, integrity, and availability of Covered Information.

3. Security Policy and Procedures. TPA shall maintain policy and procedures relating to the safeguarding of data relevant to Covered Information. TPA shall undertake reasonable efforts to maintain this program in accordance with reasonable industry practices and guidelines from HITRUST (or other similar industry body) that are designed to protect against accidental or unlawful destruction, loss, alteration, or unauthorized third-party disclosure or access to Covered Information.

4. Use of Administrative, Physical and Technical Safeguards. The written information security program and security policy and procedures are designed to clearly identify those technical and organizational measures and practices to be implemented and followed by TPA, including appropriate administrative, physical, and technical safeguards, which are intended to reasonably protect the security of Covered Information processed by TPA.

5. Evaluation of Written Information Security Program and Security Policy and Procedures. TPA agrees that it will take reasonable efforts to review and, as needed, update its written information security program and security policy and procedures at reasonable intervals and whenever there are material changes to TPA's relevant Information Systems. The Parties affirmatively recognize, however, that both information security best practices and threats to the security of Covered Information are ever evolving and therefore nothing in this Schedule should be interpreted as a contractual promise by TPA to guarantee perfection in protecting Covered Information or in meeting all information security best practices.

6. Use of Information Classification Standards. In its performance under this Agreement, TPA shall utilize information classification standards for classifying, labeling and handling of Covered Information.

7. Incident Response Program. TPA will maintain a written program plan to detect and respond to security incidents. The program will include identification, containment, mitigation, and remediation of an incident. Notification of Security Incidents, as defined under the Parties' BAA, or as may be required under applicable state data breach notification laws, shall be handled in a manner consistent with the Parties' BAA.

8. Disaster Recovery and Business Continuity and Emergency Management. TPA will maintain appropriate business continuity, disaster recovery and emergency management plans designed to enable TPA to respond to and recover from material business process disruptions in a manner that will provide for the delivery of critical services under this Agreement in timeframes that align with TPA's established recovery time objectives. TPA shall test its business continuity, disaster recovery and emergency management plans at least annually.

9. Training and Awareness. After hire and periodically thereafter, TPA shall conduct information security awareness training for TPA personnel. TPA's security policy and procedures shall periodically be published and communicated as relevant to TPA personnel directly or indirectly involved in the processing or safeguarding of Covered Information.

10. Information Security Program Review. TPA will engage in periodic security assessments, audits, and/or evaluations of its security program as it relates to the protection of Covered Information. Consistent with TPA's written information security program, these activities include relevant third party evaluation of TPA's security program, such as HITRUST CSF assessment and certification. Such reviews also include periodic internal and authorized third party network testing, such as vulnerability scans and penetration tests.

11. Access to Summarized Policies. TPA shall, upon advance reasonable request that does not exceed once per year, provide [MCHCP] with reasonable and timely access to summarized policies, as permitted by TPA's written information security program.

Schedule G
Audit Policy

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Foreword

Anthem Blue Cross Blue Shield (Anthem) regularly initiates a number of quality-focused reviews of its claims processing and operational functions. These quality activities may include a SOC 1, Type 2 examination by an external audit firm, ongoing internal claims Quality Assurance Program activities, and quarterly random claims audits. However, if an account desires additional assurance, Anthem may participate in an account audit in accordance with the provision for audits set forth in the service agreement between the account and Anthem.

This Customer Audit Policy & Procedure Manual defines the planning, preparation, roles and responsibilities required of external auditors and Anthem when an account, or an auditor acting on an account's behalf, requests a claims, operations, clinical or pharmacy audit of Anthem. The manual defines time frames for the performance of the audit as well as guidelines for charging accounts for services provided by Anthem beyond the limits of routine audits and/or what is included in Anthem's agreement with the account.

As used in this document, the term "auditors" includes all individuals who participate in claims, operations, clinical or pharmacy audits on behalf of an account, whether they are employed directly by the account or by an auditing firm engaged by the account to conduct the audit. Should an account desire to employ an independent audit firm to conduct an audit, such firm must be mutually acceptable to the account and Anthem. Anthem will not allow an audit to be conducted by auditors working on a contingency fee basis or a concurrent/pre-payment basis.

The guidelines in this document pertain specifically to account audits and provide that Anthem's Customer Audit Services Department (or such other department as may be designated by Anthem) acts as a liaison between the external auditors and other Anthem departments to coordinate the planning, preparation and execution of such audits. The document is designed for use by external auditors, representatives of accounts and internal staff in an effort to facilitate the audit process.

- **Customer Audit Policy**

- **Policy Statement**

The policies and procedures defined within this document enable Anthem to:

- Cooperate without interfering with the day-to-day operations related to claims processing and customer service
- Safeguard against the potential misuse of information
- Comply with confidentiality guidelines
- Furnish complete, accurate and timely information
- Minimize costs for Anthem and the account, and
- Comply with professional audit standards (e.g., the American Institute of Certified Public Accountants' Generally Accepted Auditing Standards, the Institute of Internal Auditors' Professional Practices of Internal Auditors and the Information Systems Audit and Control Association's Control Objectives with Information Technology).

- **Policy Scope**

These policies apply to all Anthem personnel and to all external auditors operating within the Anthem business units that have adopted this policy. In addition, Anthem personnel and external auditors shall adhere to all restrictions and/or limitations set forth in the Administrative Service Agreement (ASA) and in state and federal regulations.

- **Policy (Self-Insured Accounts)**

Anthem will cooperate fully, professionally, and efficiently with self-insured accounts requesting claims audits in accordance with their ASA.

Accounts shall have the right to audit their claims virtually, during regular business hours at their own expense. Anthem reserves the right to charge a fee to an account for expenditure of time by Anthem's employees in completing any audit. If an account chooses to use a third-party auditor to conduct an audit, such auditor must be mutually acceptable to the account and Anthem. Anthem will only approve auditors that are independent and objective and will not approve auditors paid on a contingency fee or concurrent/pre-payment basis. An auditor or consultant must execute an agreement with Anthem pertaining to the use, disclosure, and protection of Anthem's Proprietary and Confidential Information prior to conducting an audit.

An account may conduct an audit once for any given period; the same period cannot be audited twice. The audit may only relate to claims processed during the current or immediately preceding period. An account may conduct one audit per calendar year. The audit may include multiple components, e.g... claims, service, appeals, and payment integrity. The scope will be limited to three components and the scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit.

For accounts that are members of a private exchange or other third party sponsored grouping, the right to conduct an annual audit, as defined above, is subject to the terms of the exchange or third party sponsored grouping contract in force during the audit period. If the contract does not allow for a client-specific audit or only allows for an audit on an exchange or aggregate level, Anthem will charge a fee if the sample size exceeds 50 claims. The fee will be negotiated and agreed upon prior to the initiation of the audit.

In order to facilitate an audit, Anthem will release confidential information which may include names, addresses and other identifying information regarding members or Anthem business, technical and proprietary information. This confidential information is to be used only in connection with the audit and shall not be combined with data from other sources to create a new data base. The party to whom the confidential information is released must take reasonable administrative, physical and technical steps to safeguard it and prevent unauthorized disclosure of it to third parties. In any authorized use of the data the auditor may only release the confidential information in an aggregated form so as to avoid identification of any member.

To the extent that anything in this policy statement conflicts with the terms in the executed ASA, the ASA takes precedence. Additionally, special circumstances may require deviations from this policy; these must be approved by authorized Anthem personnel, such as Plan Presidents, Sales/Account Management leadership, Legal counsel, and Audit and/or Operations leadership as circumstances warrant.

▪ Policy (Fully Insured Accounts)

Anthem does not extend audit rights to fully insured accounts. However, Anthem may consider on an exception basis a fully insured account's audit request under the policy terms as are detailed above for self-insured accounts. The fully insured account must sign a protected health information report request form before Anthem will release any data to the account and/or its auditor. By signing the form, the insured account agrees to comply with all applicable HIPAA requirements, including stringent requirements that ordinarily do not apply to fully insured plans. If the account will not sign the form, the audit request must be referred to the Director, Customer Audit Services for next steps.

▪ Legal and Other Limits on Disclosure of Information

- Anthem uses and discloses member personally identifiable information (PII) and protected health information (PHI) in accordance with its Corporate Privacy Policies and operating procedures, which are designed to be compliant with the HIPAA Privacy rules, as well as other applicable state and federal privacy laws. The Policies and procedures may be amended from time to time, in accordance with applicable federal and state privacy laws and regulations.
- When audit rights are extended, the account, auditor, and Anthem are all required to comply with HIPAA and other relevant laws in handling any PII and PHI and agree to only use and/or disclose the minimum amount of such PII and PHI necessary to accomplish a permitted purpose, in accordance with these requirements. These parties must also agree to protect the confidentiality and security of this information and to ensure its proper disposal once auditing activities have been completed.
- No documents or copies of documents may be released from Anthem's facilities. If the auditor wishes to retain documents for inclusion in work papers, Anthem's advance written permission must be obtained from Customer Audit Services management.
- During the audit, if questions or concerns arise regarding the confidentiality or external disclosure of any information, Customer Audit Services will contact Anthem's Legal Department and/or Privacy Compliance and/or Information Security Office for clarification before the information is released.

▪ Audit Confidentiality Agreements

- Audit Confidentiality Agreements must be signed in advance of the audit to protect Anthem and hold external parties accountable for their uses/actions with regard to any proprietary and/or confidential information received. No claims information or other data will be released until the appropriate agreements are signed.

- The account must execute a Confidentiality Letter Agreement to cover the use/disclosure of Anthem's proprietary information each time an audit is requested. This will be initiated by Customer Audit Services upon approval of the audit scope.
- The auditor engaged by the account must execute an Audit Confidentiality Agreement (Audit Agreement) that includes indemnification. The Audit Agreement will be initiated by Customer Audit Services upon approval of the audit scope. If the account chooses to conduct its own audit, it will be required to execute an Audit Agreement rather than the Confidentiality Letter Agreement described above.
- A multi-party agreement may be required in certain situations, e.g., when an audit involves an Anthem service vendor.
- If account representatives come on site at Anthem during an audit to attend a meeting or participate in a tour, they will be required to comply with all security and confidentiality procedures in place at the applicable Anthem location. Additionally, the account representatives will be asked to sign a Visitor's Agreement related to confidentiality prior to the date of the proposed visit.

- **Provider Agreement Review**

Anthem's provider agreements and rate schedules are proprietary to Anthem and the providers. Thus, provider agreements and/or rate schedules will not be permitted to be reviewed in their entirety. If requested in the audit scope letter Anthem may share applicable portions of certain contracts during an audit. Such portions disclosed will be strictly limited to those necessary to support payment of a specific sample claim. The 15 claims must be identified in the sample prior to the audit. No auditor will be permitted access to more than 15 provider agreement excerpts.

Review of provider agreement excerpts will be limited to Anthem contracted providers in Anthem's service areas. Anthem is unable to obtain copies of provider contracts and/or rate schedules from other Blue Cross Blue Shield Plans. If an account/auditor would like to review contracts at a non-Anthem Plan, the request should be submitted to Customer Audit Services. Customer Audit Services will contact the Plan(s) to determine their willingness to share those contracts and will facilitate the auditor's visit to the Plan if appropriate.

- **Customer Audit Procedures**

- **Initial Account Audit Request**

- An account, or its auditor, should communicate a request for an audit through the Account Manager or directly to Customer Audit Services.
- The auditor or customer must provide Customer Audit Services with details on the proposed scope and requirements of the audit in writing. This information may be provided in the form of an audit work program or an audit scope letter. Under no circumstances will an audit commence in the absence of an audit scope document.
- The scope document should include the following information:
    - Audit purpose and objectives
    - Audit scope (including the time period being audited)
    - Sampling methodology and expected sample size
    - Detailed description of the data requested for sample selection, including the following:
    - Audit time period
    - Specific data element requirements, no abbreviations or acronyms
    - Plan(s) to be included
    - Programs to be included, e.g. (claims, clinical, accumulator, service)
    - Data format
    - Description of documentation desired to be reviewed virtually
    - Timetable for the audit including the time the external auditors expect to spend reviewing documentation virtually and information critical to the scheduling of the audit
    - Description of post-review audit activities and timeframes, e.g., draft report for management response and final report
    - A copy of the external auditor's audit guidelines and performance standards (if available)
- Audits may be conducted by the account's internal audit staff or by a third party. However, accounts who are also healthcare providers are not permitted to audit their own group health plans. Healthcare providers must engage third-party auditors so that Anthem can prevent the disclosure of competitively sensitive information.
- Customer Audit Services will coordinate all account audits. No commitments may be made regarding the timing, scope, or other details of the audit without the knowledge and consent of Customer Audit Services.
- Anthem must receive the scope letter and agree to the audit scope at least 60 days prior to their proposed virtual review time in order to ensure that Anthem will have adequate time to schedule staffing and prepare for the audit.

- Anthem will do its best to accommodate the requested virtual audit date. If the date is not available, Anthem will propose the next later available date.

Audit Limitations

- Approval for an audit will be based upon various business factors, including but not limited to the type of audit, the auditing organization, the contractual basis for the audit, and whether the scope of the audit is reasonable.
- The scope of the audit shall be agreed to by all Parties prior to the commencement of the audit.
- Random sample claim audits will generally be limited to no more than 250 claims and the sample must be free of bias, influence or conflict of interest. Samples sizes in excess of 250 claims may be permitted by Anthem, subject to additional fees. Sample size restrictions for electronic audits are addressed in the Electronic Audits section below.
- Combination (random and focused/targeted) sample audits will be limited to 50 focused/targeted claims, not to exceed the 250 overall limitation.
- Contingency fee-based audits or audits conducted on a concurrent or pre-payment basis will not be permitted.
- An account may conduct an audit once for any given period; the same period cannot be audited twice. The audit may only relate to claims, service and appeals processed during the current or immediately preceding contract year or calendar year.
- No more than one audit for a particular account shall be conducted during a calendar year. Requests for additional audits will be considered for approval (with potential fee implications) on a case-by-case basis. The annual limit does not apply to audits related to the filing of the ERISA 5500 form.
- For accounts with Joint Adjudication Arrangements (JAA) only audits of claims pricing are feasible. Such audits may be performed by the account, an auditor, or a third-party administrator (TPA) on behalf of the account. Additional audit limitations may be enforced if the audit is to be performed by the TPA depending upon the nature of the business relationship between Anthem and the TPA. In all cases, the necessary confidentiality agreements must be in place and the auditor must provide sufficient details on the sample claims to allow for re-pricing. Claims payment verification will be accomplished through a review of the subscriber Explanations of Benefits available for the JAA account.
- Anthem will not agree to requests for reimbursements based on the use of extrapolation methodologies to infer errors in a population of claim payments based upon the error rate in a sample drawn from that population. Instead, Anthem will identify all impacted claims. Anthem will adjust overpayments on a claim-by-claim basis following standard Anthem overpayment recovery guidelines and processes. Anthem will also resolve underpayments on a claim-by-claim basis. Impact reporting will be generated for identified and agreed upon systemic issues. Anthem will not generate impact reports for manual processing errors or for non-systemic issues identified by a targeted-focused sampling methodology.

Questionnaires and/or Operational Assessments

An external auditor may submit an informational or procedural questionnaire for Anthem to complete so that the auditor may have a better understanding of its operations. These questionnaires will be forwarded to the appropriate personnel (e.g., the Proposal department) for a written response.

- Anthem must receive the questionnaire by an agreed upon date as far in advance of the virtual date as possible in order for Anthem to have adequate time to respond and to accommodate any internal review requirements. If Anthem does not receive the questionnaire by the agreed-upon date, no written response will be provided.
- Customer Audit Services will coordinate a meeting, if requested by the external auditor, to review the written response. This meeting will be a teleconference unless the account expressly requests the meeting take place at an Anthem location. Subject matter experts will be available to respond to the auditors' questions.

Anthem will evaluate each request for questionnaire completion and operational assessment and reserves the right to decline the request if there has been no material or significant change that could have impacted the accuracy of claims processing or the delivery of customer service since the last questionnaire or assessment.

Scheduling and Sample Selection

- Customer Audit Services will schedule the virtual portion of the audit. The virtual review should last no longer than five (5) working days unless otherwise agreed. It is expected that the external auditor will appropriately staff the engagement.

- The auditor's sample selection must be provided to Customer Audit Services no later than four (4) weeks prior to the agreed upon date for the start of the virtual review. Customer Audit services will confirm the audit date upon receipt of the audit sample. Anthem is willing to discuss potential audit dates upon receipt of the scope letter but will not schedule the audit or confirm the date until the audit sample is received.
- At least four (4) weeks prior to the start of the audit, a list of all persons expected to be working virtually at any time during the audit should be provided to Customer Audit Services. Customer Audit Services will arrange appropriate virtual workspace for the external auditors and for system access. Auditors working virtually should plan to work during Anthem's normal hours of operation, generally 8:00 a.m. to 5:00 p.m. (may vary by location). Requests for additional hours must be submitted at least a day in advance.
- Standard record layouts and data dictionaries have been developed for claims audits by Anthem, in accordance with its corporate Data Release Policy. These contain data fields sufficient for sample selection and/or data analysis. Non-standard audit sample data requirements will be discussed upon receipt of the scope letter. Non-standard data requests may be declined or may result in an additional cost to the account or external auditor. The standard record layout does not include provider identifying information (Tax IDs or NPI numbers) in an unscrambled format. Requests for unscrambled provider information or other provider information (name and address) will not be considered.
- Under Anthem's Data Release Policy, the Customer Audit Services Director may be required to seek recommendations from various sources prior to making a data release decision.
- Customer Audit Services will provide the data on encrypted media or through a secured web site. The auditor is only permitted to use the data to perform the agreed upon audit procedures.
- Once the sample is selected, the auditor must provide a sample list that includes at least the following data elements: claim number, document control number (DCN), SCCF #, subscriber identification number, date of service, paid date and amount paid. Each sampled item should be assigned a unique sample number.
- The amount of time required to retrieve the documentation for an audit is at least 30 business days. However, this time frame may vary based upon the sample size, the type of documentation requested, and the age of the documentation. Audit documentation is pulled on a first in first out basis.

Access to Anthem Information and Claims Systems

- The external auditor will be given direct physical access to Anthem's systems only in instances where:
  - Such access complies with Anthem's Privacy and Security policies, as they may be amended from time to time, and
  - The data can be accessed in a manner that protects Anthem's proprietary and confidential information.
- In all other instances, Anthem will print out reasonable requests for documentation when requested in compliance with the terms of this Policy. The paper documentation will be redacted to conceal PII and PHI if the auditor is an employee of the account. This step will not be required if the account provides a letter stating that the auditor is authorized to view PII and PHI.

Virtual Review

- The review of sample claims must occur virtually via one of Anthem's audit locations. No claim materials, screen prints or other information provided during the course of the audit may be retained by the auditors.
- Customer Audit Services will arrange appropriate virtual workspace.
- When system access is provided, the following documentation will be pulled to support each sampled item as appropriate: paper claim or image of paper claim, and pricing information. This documentation will be provided on the virtual desktop (to be accessed virtually via an Anthem audit connection). Requests for additional documentation must be included in the scope letter and will be considered on an individual basis.
- Upon request from the auditor, account or Anthem, a formal entrance conference will be scheduled for the first day the auditors are working virtually.
- Customer Audit Services will be the auditors' main contact during the audit and will assign appropriate staffing to coordinate audit activities. All requests from the external auditors for information (claim data, procedures, interviews, questions, potential errors, etc.) must be submitted in writing to the assigned Customer Audit Services coordinator.
- Auditors will observe Anthem's working hours, generally 8:00 a.m. to 5:00 p.m. (may vary by location). Requests for extended hours will be considered if submitted at least a day in advance. Extra hours will not be considered prior to the start of the audit. Auditors are expected to staff appropriately to handle the sample size in the standard allotted hours.
- An exit meeting will be scheduled at the conclusion of the virtual review. This exit meeting may be held while the auditor is working virtually or at such time as Anthem has responded to all outstanding questions and issues. The exit conference will include a discussion of interim findings and observations, the timeframe for responding to outstanding audit questions (if necessary), report and report response delivery dates and any other next steps.

Audit Reports

- Draft and/or final reports should be sent to Customer Audit Services. Anthem expects to receive copies of reports according to the terms of the Audit Confidentiality Agreement signed by Anthem and the auditor.
- Anthem will have a minimum of 15 business days to respond to the draft audit report.
- Customer Audit Services will distribute the report internally to the appropriate areas for review and response.
- Customer Audit Services will draft Anthem's response letter and will ensure review and approval by claims operations management and account management prior to releasing the response to the auditor.
- A copy of Anthem's response to the audit report must be included, in its entirety, in the final audit report.

Claim Adjustment Procedure

- Claim errors identified in the audit that are confirmed by Anthem Customer Audit Services and the appropriate Anthem operational unit will be corrected on a claim-by-claim basis pursuant to Anthem's recovery and adjustment policies and procedures.
- In the event a systemic discrepancy is identified, an impact analysis will be generated by Anthem to identify the total number of claims impacted for the audit period and to determine the final amount owed to the group and/or member(s). The CAS audit coordinator will notify the Anthem Account Manager and/or the external auditor of the final impact and reimbursement will be arranged. Reimbursement will be made in accordance with the ASA agreement, which may include but is not limited to claim adjustments or in the form of a credit on the client's invoice. The form of reimbursement will be determined by Anthem. Impact reporting will not be provided for agreed upon manual processing errors.
- Claim adjustments will be made according to the terms of the contracts or other applicable arrangements between Anthem and its providers, the ASA between the account and Anthem, and all applicable laws and regulations related to such adjustments (including laws restricting time limits for adjustment).

Electronic Audits

Electronic audits are focused audits that do not involve a randomly selected sample of claims. Instead, these audits involve a computer analysis of a detailed claim file for a given date range. Electronic audits are often performed on a contingency fee basis. Anthem does not permit audits performed on a contingency fee basis; therefore, the customer and auditor must confirm in writing that the compensation arrangement is not contingency fee, or a combination of fixed and contingency fee based.

The following outlines the level of support that Anthem will provide for electronic audits:

- Electronic review will be limited to accuracy of account specific benefit adjudication and will not include categories that involve clinical judgment, provider bill accuracy or medical code edits. If the review goes beyond benefit adjudication concerns, Anthem will address those concerns generically and will not address each specific coding combination or finding. Anthem processes all claims according to Anthem medical/payment policies and provider contracts.
- The virtual review will be limited to 150 claims and will last no more than five (5) business days. Requests for sample size exceptions will be considered and Anthem will charge the customer for the additional work effort involved when the exception request is granted.
- Auditor will identify claim categories to be reviewed (e.g., duplicates). Claim categories will be defined in advance and mutually agreed upon by the parties.
- Anthem will review the potential overpayments and agree or disagree based on all relevant factors including Anthem's reasonable claim administration policies and practices.
- In situations where Anthem and the auditor do not agree as to whether an overpayment exists, Anthem will request that the account resolve the dispute and make a determination.

Implementation Audits

These audits are typically performed prior to the effective date of an account's contract period to test readiness for claims processing by verifying the accuracy of benefit coding and/or eligibility information in the system.

- Implementations not involving benefit changes will be ineligible for an implementation audit. (Example: An implementation audit for an account adding new subgroups without any changes to the current benefit structure will not be accommodated.) *

- A scope letter must be submitted to Anthem Sales, Account Management, and Customer Audit Services when the intent to audit is confirmed. The scope should be submitted three months prior to the implementation date. Typically, 9/1 prior to the 1/1 effective date. Scope letters received after 9/1 could result in the delay of the audit.
- Timing of the implementation audit can only be defined once Anthem obtains the account's sign-off on the benefit plan designs and a benefit coding and internal testing schedule is developed. Any changes to benefits after the initial sign-off may lead to a postponement of the audit.
- Anthem benefit coding and internal testing needs to be completed before preparation work for the implementation audit can begin.
- Implementation audits for new business will be scheduled based on a mutually agreeable time frame established by Customer Audit Services and the account or auditor.
- Anthem will attempt to schedule implementation audits prior to the account's effective date when possible. Audits for January implementations will typically be scheduled beginning in late November and will run through February.
- A signed confidentiality agreement must be received by Anthem from the auditor prior to the designated audit commencement date.
- The audit will be conducted via a webinar utilizing WebEx Meeting functionality.
- Customer Audit Services maintains a set of over 250 test scenarios (test bed) covering a broad range of services for implementation audit use. The auditor will select specific test scenarios from the test bed for review. There will be a limit of 75 test scenarios per plan up to a maximum of 375 claims across all plan designs. *
- The test claim selections must be received by Customer Audit Services 4 weeks prior to the audit date. If selections are not received timely, there may be a postponement of the audit.
- Validation of benefit accuracy shall be measured using the Anthem plan designs approved by the account at benefit sign-off.
- Following the audit, a correction plan (including timeline) will be provided for any issues identified during the audit.
- Operational assessments will be coordinated on behalf of the account by the Customer Audit Services.

* Requests for exceptions must be submitted with the confirmation of intent to audit. Such requests will be reviewed and approved by Customer Audit Services (with input from Anthem Sales and Account Management) within five (5) business days of receipt. Approved exceptions will be handled during the peak period (late November – February). All other exceptions will be deferred until March or later depending upon resource availability.

▪ Accumulator Audits

Accumulator audits are performed to confirm shared accumulations of deductible, copayment and coinsurance between the medical plan, the pharmacy plan, and third-party medical vendor are accumulating correctly.

- These audits should be performed in conjunction with an implementation audit no later than three months of the group's implemented effective date.

  The samples are typically made up of a judgment (non-statistical) sample and will be limited to 25 member's files.
- The scope letter must include the accumulator component and must be submitted to Anthem Sales, Account Management, and Customer Audit Services when the intent to audit is confirmed.
- Timing of the audit can only be defined once the implementation audit has been conducted and the group has at least two months of claims experience.
- Accumulator audits will be a part of an implementation or claims audit. Requests for accumulator audits separate from an implementation or claims audit will not be considered.

▪ Program Integrity Aligned Incentives

▪ OVERVIEW:

Anthem Blue Cross Blue Shield (Anthem) regularly initiates a number of quality-focused reviews of claims processing and operational functions. These quality activities may include a SOC 1, Type 2 examination by an external audit firm, ongoing internal claims Quality Assurance Program activities, and quarterly random claims audits. However, if an account desires additional assurance, Anthem may participate in an account audit in accordance with the Article 12 – Claims Audit provision, set forth in the ASA (Administrative Services Agreement) between the account and Anthem.

This ASO Client Audit Policy & Procedure Manual defines the planning, preparation, roles and responsibilities required of external auditors and Anthem when an account, or an auditor acting on an account's behalf, requests an audit of Anthem's Program Integrity Aligned Incentive (PIAI) program, specifically outlined in Article 13 – Recovery and Prepayment Analysis Services. The manual defines timeframes for the performance of the audit as well as guidelines for charging accounts for services provided by Anthem beyond the limits of routine audits and/or what is included in Anthem's agreement with the account.

As used in this document, the term "auditors" includes all individuals who participate in claims, operations, or program integrity services on behalf of an account, whether they are employed directly by the account or by an auditing firm engaged by the account to conduct the audit. Should an account desire to employ an independent audit firm to conduct an audit, such firm must be mutually acceptable to the account and Anthem. Anthem will not allow an audit to be conducted by auditors working on a contingency fee basis or a concurrent/pre-payment basis.

The guidelines in this document pertain specifically to Program Integrity services performed on behalf of an account invoice audit and is considered a separate and distinct audit from a Claims Audit performed by Anthem's Customer Audit Services team. The Customer Audit Services team shall act as a liaison between the external auditors and Program Integrity Aligned Incentive team and will serve as the initial contact for such audits. This document is designed for use by external auditors, representatives of accounts and internal staff in an effort to facilitate the Program Integrity audit process.

▪ ACRONYMS AND ABBREVIATIONS:

Frequently used acronyms and abbreviations utilized within this manual and conversations.

ANA = Anthem National Accounts
ASA = Administrative Service Agreement
ASO = Administrative Services Only
C&I = Confidentiality and Indemnification Agreement
CAS = Customer Audit Services
CAU = Contract Administration Unit
COB = Coordination of Benefits
CPI = Claims Payment Integrity
CSBD = Commercial Specialty Business Division
CXT = ClaimsXten (claims editing software developed by McKesson)
DCN = Document Control Number
DRG = Diagnosis Related Grouper
EDI = Electronic Data Interchange
FIR = Funding Information Request
FWA = Fraud, Waste, Abuse
HIPAA = Health Insurance Portability and Accountability Act establishes national privacy standards to protect patient medical information and other health information provided to health plans, doctors, hospitals and other health care providers.
ITS = InterPlan Transfer System (BlueCard Program)
MRC = Missing Recovery Code
NASCO = National Accounts Service Company
OHI = Other Health Insurance
PI = Program Integrity or Payment Integrity
PIAI = Program Integrity Aligned Incentive
PG = Performance Guarantee
PMPM = Per Member Per Month
PSPM = Per Subscriber Per Month
QCR = Quality Code Review (Provider Auditing performed by Nurses and Certified Coders)
RAC = Recovery Adjusters & Collections (Claim level SMEs)
RDA = Recovery Data Analysis (Analysts)
RMB = Revenue Management & Billing (ASO Billing System)

RPM = Reimbursement Policy Management (Claims Editing vendor process)
SCCF = *(Standard Claims Collection Facility)* Number assigned by ITS Host
SOC 1 = System and Organization Controls
SOW = Statement of Work or Scope of Work
SIU = Special Investigations Unit (investigation of fraud, waste, abuse)
Subrogation = 3rd party liability (car, homeowner's insurance, worker's comp, mass tort, etc.)
UW = Underwriting
WGS = Commercial Local large group platform

- **ASO PIAI AUDIT POLICY:**

Anthem will cooperate fully, professionally and efficiently with ASO accounts requesting an audit of Anthem's Program Integrity Aligned Incentive program (i.e., shared savings) in accordance with their Administrative Service Agreement.

The policies and procedures defined within this document enable Anthem and External Account Auditors to:

- Cooperate without interfering with the day-to-day operations related to claims processing
- Safeguard against the potential misuse of information
- Comply with confidentiality guidelines
- Furnish complete, accurate and timely information specific to PI services
- Follow PHI and HIPAA Minimum Necessary Standard guidelines
- Minimize costs for Anthem and the account, and
- Comply with professional audit standards (i.e., The American Institute of Certified Public Accountants' Generally Accepted Auditing Standards, The Institute of Internal Auditors' Professional Practices of Internal Auditors and the Information Systems Audit and Control Association's Control Objectives with Information Technology.)

- **ASO PIAI POLICY SCOPE:**

This policy applies to all Anthem personnel and to all external account auditors operating within the Anthem business units that have adopted this policy. In addition, Anthem personnel and external account auditors shall adhere to all restrictions and/or limitations set forth in the Administrative Service Agreement and in State and Federal Regulations.

The scope of such audits may include, but shall not be limited to, a review of:

- Account Enrollment and Billing Setup
- PIAI Participation Status
- Claim Validation of Shared Savings Calculations and Associated Fees

Accounts shall have the right to audit Anthem's Program Integrity Aligned Incentive program (i.e., shared savings) virtually or on Anthem's premises, during regular business hours at their own expense. We expect Accounts to complete their work virtually or onsite in no more than 5 business days. Anthem reserves the right to charge a fee to an account for expenditures of time by Anthem's associates in completing an audit. If an account chooses to use a third-party auditor to conduct an audit, such auditor must be mutually acceptable to the account and Anthem. Anthem will only approve auditors that are independent and objective and will not approve auditors paid on a contingency fee or other similar basis. Accounts will be responsible for reimbursing the independent audit firms for any charges or expenses they incur in performance of the audit. These charges may include, but are not limited to, travel expenses, supplies, fees, salaries and wages, commissions and recovery fees. We reserve the right to charge a fee to an account for expenditures of time by our employees in completing any audit. Anthem does not agree to share in the cost of any audit proven unsatisfactory based on agreed upon performance standards.

An account may conduct an audit once for any given period; the same period cannot be audited twice. A period is defined as the account's plan year (contract year, renewal, or calendar year). The audit may only relate to complete payments processed during the current or immediately preceding period. An account may conduct one audit per calendar year. The scope of the audit shall be agreed to in writing by all parties prior to the commencement of the audit. The auditor or consultant must execute an agreement with Anthem pertaining to Anthem's Proprietary or Confidential Information prior to conducting the audit. Due to the nature of the Program Integrity Vendor Services, it may not be possible to share certain data (i.e., Vendor Contracts, Intellectual Properties, Fee Agreements, etc.) despite the confidentiality agreement signed by the external auditor. Anthem will inform the account, auditor and/or consultant of any data limitation prior to the commencement of the audit. The auditor or customer must provide the PIAI Client Management Team with details on the proposed scope and requirements of the audit in writing. This information may be provided in the form of an audit work program or an audit scope letter and approved by the ASO CSBD PIAI Program Director.

In order to facilitate an audit, Anthem will release minimum necessary confidential information which may include names, addresses and other identifying information regarding members or Anthem business, technical and proprietary information. This confidential information is to be used only in connection with the audit and shall not be combined with data from other sources to create a new data base. The party to whom the confidential information is reviewed must take reasonable administrative, physical and technical steps to safeguard it and prevent unauthorized disclosure of it to third parties. In any authorized use of the data the auditor may only review the confidential information in an aggregated form so as to avoid identification of any member.

To the extent that anything in this policy statement conflicts with the terms in the executed Administrative Service Agreement, the Administrative Service Agreement shall take precedence. Additionally, special circumstances may require deviations from this policy; these must be approved by authorized Anthem personnel, such as Plan Presidents, Sales/Account Management leadership, Legal counsel, and Audit and/or Operations leadership as circumstances warrant.

▪ AUDIT LIMITATIONS:

The approval for the PIAI audit will not be given until Anthem has received an engagement or scope letter. Approval for an audit will be based upon various business factors, including but not limited to the type of audit, the auditing organization, the contractual basis for the audit, and whether the scope of the audit is reasonable. Anthem reserves the right to limit the sample size and the amount of time that an external audit team may be virtually or onsite and/or requesting resources. Samples or timeframes in excess of these limits, if permitted by Anthem, may be subject to administrative charges. Anthem also reserves the right to limit audits to one per contract or calendar year and to limit the scope of an audit to the current or immediately preceding benefit year. Requests for additional audits will be reviewed for approval and possible pricing on a case-by-case basis.

- The ASO Payment Integrity Aligned Incentives Client Audit is specific to Program Integrity services performed on behalf of an account participating in the PIAI (Shared Savings) Program and is considered a separate distinct audit from the Claims Audit (Article 12) performed by the Claims Audit Services team. Anthem reserves the right to limit audits to one per contract or calendar year.
- Anthem's contracts with providers are proprietary to Anthem and the provider. Thus, provider contracts, rate schedules and/or reimbursement rates will not be permitted to be reviewed. Provider contract audits are excluded from the scope of the PIAI audit policy. Anthem uses and discloses member personally identifiable information (PII) and protected health information (PHI) in accordance with its Corporate Privacy Policies and operating procedures, which are designed to be compliant with the HIPAA Privacy rules, as well as other applicable state and federal privacy laws. Policies and procedures may be amended from time to time, in accordance with applicable federal and state privacy laws and regulations.
- When audit rights are extended, the account, external auditor and Anthem are all required to comply with HIPAA and other relevant laws in handling any PII and PHI and agree to only use and/or disclose the minimum amount of such PII and PHI necessary to accomplish a permitted purpose, in accordance with these requirements. Parties must also agree to protect the confidentiality and security of this information and to ensure its proper disposal once auditing activities have been completed.
- No documents or copies of documents may be removed from Anthem's facilities.
  If the external auditor wishes to retain documents for inclusion in work papers, an agreement to allow for this must be reached during the negotiation of the Audit Agreement.
- During the audit, if questions or concerns arise regarding the confidentiality or external disclosure of any information, a representative of the ASO PIAI Program Management Team will contact Anthem's Legal Department and/or Privacy Compliance and/or Information Security Office for clarification before the information is released.

▪ AUDIT CONFIDENTIALITY:

Audit Confidentiality Agreements must be signed in advance of the audit to protect Anthem and hold external parties accountable for their uses/actions with regard to any proprietary and/or confidential information received. No claims information or other data will be reviewed until the appropriate agreements are signed.

An agreement will be negotiated with the account to cover the use/disclosure of Anthem's proprietary information each time an audit is requested. This agreement will be in the form of a letter (Confidentiality Letter) and will be initiated by Customer Audit Services upon approval of the audit scope. The audit scope must be reviewed by the ASO PIAI Client Management Team and approved by ASO CSBD PIAI Program Director. An authorized representative of the account

and an authorized representative of Anthem must sign the Confidentiality Letter. If the account conducts its own independent audit, it will be required to execute an Audit Confidentiality Agreement as described in the next paragraph.

An Audit Confidentiality Agreement (Audit Agreement) must be executed with the external auditor, or with the account conducting its own audit. The Audit Agreement will be initiated by Customer Audit Services upon approval of the audit scope. The audit scope must be reviewed by the ASO PIAI Client Management Team and approved by ASO CSBD PIAI Program Director. An authorized representative of the external audit firm (or the account, as the case may be) and an authorized representative of Anthem must sign the Audit Agreement. There may be cases where a three-party agreement would be required. These audits would involve an Anthem service vendor.

If an auditor or account representative comes onsite during the audit, they will be required to comply with all security and confidentiality measures in place at the applicable Anthem location.

- **LEGAL AND OTHER LIMITS ON DISCLOSURE OF INFORMATION:**

Anthem uses and discloses member PHI in accordance with its Corporate Privacy Policy Manual and operating procedures. The policy provisions support Anthem's compliance with the HIPAA Privacy rules, as well as other state and federal laws designed to protect and limit the use and disclosure of PHI. The policies may be amended from time to time, in accordance with applicable federal and state privacy laws and regulations. The account, external auditor, and Anthem are all required to comply with HIPAA and other relevant laws in handling any PHI and agree to only use and/or disclose the minimally necessary amount of such PHI in accordance with these requirements. Parties must also agree to protect the confidentiality of this information and ensure its proper "disposal" once auditing activities have been completed.

No documents or copies of documents may be removed from Anthem's facilities. If the external auditor wishes to retain documents for inclusion in work papers, an agreement to allow for this must be reached during the negotiation of the Audit Agreement.

During the audit, if questions or concerns arise regarding the confidentiality of any information, Customer Audit Services will contact Anthem's Legal Department and/or the Privacy and Security Office for clarification before the information is released.

- **ASO PIAI CLIENT AUDIT PROCEDURES:**

Initial Account Audit Requests:

- An account, or its auditor, should communicate a request for an audit through the Account Manager or submit intent directly to the Anthem Customer Audit Services.
- The auditor or customer must provide the PIAI Client Management Team with details on the proposed scope and requirements of the audit in writing. This information may be provided in the form of an audit work program or an audit scope letter. Under no circumstances will an audit commence in the absence of an audit scope document.
- The scope document should include the following information:
    - Audit purpose and objectives
    - Audit scope (including the time period being audited)
        - Sampling methodology and expected sample size (not to exceed 50 invoices per Account Audit).
        - Detailed description of the data requested for sample selection, including the following:
        - Audit time period (current or immediately preceding benefit year)
        - Specific data element requirements, no abbreviations or acronyms
        - Plan(s) to be included
        - Data format
    - Description of documentation desired to be reviewed onsite
    - Timetable for the audit including the time the external auditors expect to spend onsite at Anthem and information critical to the scheduling of the audit
    - Description of post-onsite audit activities and timeframes, e.g., draft report for management response and final report
    - A copy of the external auditor's audit guidelines and performance standards (if available)

- Audits may be conducted by the account's internal audit staff or by a third party. However, accounts who are also healthcare providers are not permitted to audit their own group health plans. Healthcare providers must engage third-party auditors so that Anthem can prevent the disclosure of competitively sensitive information.

- Customer Audit Services will coordinate all account audits. No commitments may be made regarding the timing, scope, or other details of the audit without the knowledge and consent of Anthem's Customer Audit Services.
- Anthem must receive the scope letter and agree to the audit scope at least 60 business days prior to their proposed virtual or onsite review time in order to ensure that Anthem will have adequate time to schedule staffing and prepare for the audit. In addition, before the planning phase can begin, the external auditor will be required to communicate key information about the audit to our PIAI ASO Client Management Team by means of a formal scope letter. Upon receipt of the letter, we will schedule a planning session, if requested, with the external auditors and representatives from our PIAI ASO Client Management Team, Account Manager (local), Operations and Customer Audit Services departments.
- Anthem will do its best to accommodate the requested audit date, virtually or at one of its audit locations. If the date is not available, Anthem will propose the next later available date.

- **SCHEDULING AND SAMPLE SELECTION:**

- PIAI ASO Client Management Team will schedule the virtual or onsite portion of the audit when the audit is focused solely on the Program Integrity Aligned Incentive program. The onsite should last no longer than five (5) working days unless otherwise agreed. It is expected that the external auditor will appropriately staff the engagement.
- The auditor's sample selection must be provided to PIAI ASO Client Management Team no later than 30 business days prior to the agreed upon date for the start of the onsite review. If the sample size exceeds 50 invoices, per Account audit, additional time may be necessary and will be communicated to the external auditor.
- PIAI ASO Client Management will confirm the audit date upon receipt of the audit sample. Anthem is willing to discuss potential audit dates upon receipt of the scope letter but will not schedule the audit or confirm the date until the audit sample is received.
- At least 30 business days prior to the start of the audit, a list of all persons expected to be onsite at any time during the audit should be provided to PIAI ASO Client Management. Auditors whether virtually or onsite, should plan to work during Anthem's normal hours of operation, generally 8:00 a.m. to 5:00 p.m. (may vary by location). Requests for additional hours must be submitted at least a day in advance.
- Once the sample is selected, the external auditor must provide a sample list that includes at least the following data elements:
    - Claim number, Document Control Number (DCN), SCCF#, Subscriber identification number, Date of Service, Paid Date and Amount Paid.
    - Each sampled item should be assigned a unique sample number and coordinated with Anthem and auditors.
- The amount of time required to retrieve the documentation for audit review is at least 30 business days. However, this timeframe may vary based upon the sample size, the type of documentation requested, and the age of the documentation.

- **VIRTUAL OR ONSITE:**

- The review of sample claims must occur virtually or onsite at one of Anthem's audit locations. No claim images, screen prints or other information provided during the course of the audit may be retained by the auditors.
- Upon request from the account, auditor or Anthem, a formal entrance conference will be scheduled for the first day the auditors are engaged, virtually or onsite.
- PIAI ASO Client Management will be the auditors main contact during the audit and will assign appropriate staffing to coordinate audit activities. All requests from the external auditors for information (claim data, procedures, interviews, questions, potential errors, etc.) must be submitted in writing to the assigned PIAI ASO Client Management, Account Services Manager.
- Auditors will observe Anthem's working hours, generally 8:00 a.m. to 5:00 p.m. (may vary by location). Requests for extended hours will be considered if submitted at least a day in advance.
- An exit meeting will be scheduled at the conclusion of the review. This exit meeting may be held while the auditor remains virtual, onsite or at such time as Anthem has responded to all outstanding questions and issues. The exit conference will include a discussion of interim findings and observations, the timeframe for responding to outstanding audit questions (if necessary), report and report response delivery dates and any other next steps.
- Anthem will response to interim findings and observations within 15 business days.

- **AUDIT REPORTS:**

- Draft and/or final reports should be sent to Anthem's ASO CSBD PIAI Program Director, and PIAI Client Management Team. Anthem expects to receive copies of reports according to the terms of the Audit Confidentiality Agreement signed by Anthem and the auditor.

- Anthem will have a minimum of 15 business days to provide a formal response to the audit report.
- PIAI Client Management Team will distribute the report internally to the appropriate areas for review, response and approval (prior to distribution to the account auditors).
    - PIAI Client Management Team will draft Anthem's response letter and will ensure review and approval by appropriate PI Claims Operations Management, Account Management and Anthem's ASO CSBD PIAI Program Director prior to releasing the response to the auditor.
- The final audit report must include a copy of Anthem's response to the audit report and the appropriate approvals.

- **AUDIT FINDINGS:**

- Claim errors identified in the audit that are confirmed by ASO CSBD PIAI Program Director, PIAI Client Management Team and the appropriate Anthem Claims Operational unit will be corrected on a claim-by-claim basis pursuant to Anthem's recovery and adjustment policies and procedures.
- Claim adjustments will be made according to the terms of the group contract or other applicable arrangements between Anthem and its providers, the Administrative Service Agreement between the account and Anthem, and all applicable laws and regulations related to such adjustments (including laws restricting time limits for adjustment).
- PIAI billing errors identified in the audit that are confirmed by ASO CSBD PIAI Program Director and PIAI Client Management Team will be corrected pursuant to Anthem's recovery and adjustment policies and procedures by PIAI Billing Operations upon appropriate approvals. Upon completion, notice of impact will be provided to ASO CSBD PIAI Program Director and PIAI Client Management.

Pharmacy Benefits - Client Audit Policy

- **Overview**

This policy applies to Anthem clients who have pharmacy benefits through Anthem.

The Anthem Pharmacy Audit Policy outlines the procedures for planning and preparing for an audit of pharmacy claims, benefits and operations. Pharmacy Audit Operations (PAO) resources will participate in an external account audit in accordance with the provision for audits set forth in the service agreement between the account and Anthem. As used in this document, the term "external auditor" includes all individuals who participate in a claims, financial guarantee and/or operations audit on behalf of an account, whether they are employed directly by the account or by an auditing firm engaged by the account to conduct the audit.

The Pharmacy Policy specifically addresses audit activities undertaken by PAO in order to facilitate a pharmacy audit. The document is designed for use by an external auditor and internal staff in an effort to facilitate the pharmacy audit process.

The policy defines the roles and responsibilities required of an external auditor and PAO in addition to defining timeframes for specific pharmacy audit activities. This policy provides for the PAO audit coordinator to act as the liaison between the external auditors, the PBM, as well as between the external auditors and other Anthem departments, such as operational departments within PAO and Anthem's Customer Audit Services. This policy does not apply to CMS Part D audits.

- **Client Audit Policy (Self-Insured Accounts)**

Anthem will cooperate fully, professionally, and efficiently with self-insured accounts requesting claims audits in accordance with their Administrative Services Agreements (ASA).

In order to facilitate an audit, Anthem will release confidential information which may include names, addresses and other identifying information regarding members or Anthem business, technical and proprietary information. This confidential information is to be used only in connection with the audit and shall not be combined with data from other sources to create a new data base. The party to whom the confidential information is released must take reasonable administrative, physical and technical steps to safeguard it and prevent unauthorized disclosure of it to third parties. In any authorized use of the data the auditor may only release the confidential information in an aggregated form so as to avoid identification of any member.

- **Client Audit Policy (Fully Insured Accounts)**

Anthem does not allow pharmacy audit rights to fully insured accounts.

▪ Audit Confidentiality Agreements

PAO requires the agreements described on page 4 above. In the event the signing of the Client Letter and Confidentiality Agreement are coordinated by Anthem's Customer Audit Services department, PAO will require a copy of the agreement prior to releasing requested audit information.

▪ Pharmacy Benefits - Client Audit Request, Scope and Planning Session

Announcement of a pharmacy audit may be sent to PAO from Anthem Customer Audit Services, the Account Manager, and/or from an external third-party auditor. The PAO audit coordinator will provide acknowledgment of the audit announcement within seven (7) business days of receipt. PAO will require adequate time to prepare for an audit in order to help ensure adequate staffing and preparation. A definitive timeline for the audit cannot be given until PAO has been provided with an audit scope document.

At minimum the audit scope document must include the following information:

- Audit purpose and objectives
- Audit scope (including the time period being audited, which is limited to the current and immediately preceding contract period)
- Sampling methodology
- Detailed description of the data requested for the claim extract and sample selection. The following must be included in the request:
    - Audit time period
    - Requested data elements
    - Group(s) to be included
- Requested pharmacy benefit design information (i.e., refill-too-soon limitations, exclusions, deductibles, pricing discounts, etc.)
- Request for pharmacy EOB/remittance

The PAO audit coordinator will review the scope document and determine what information can be provided for the audit. Consultation with the PBM, Legal or other functional areas within PAO may occur to determine the information that will be released for the audit. Once the review is complete and the request has been approved the audit coordinator will provide a timeline for releasing the requested information. If it is determined that PAO cannot release requested information Anthem's Customer Audit Services and the external auditor will be notified. Information may not be released for various reasons including, but not limited to:

- The requested information is proprietary.
- The requested information does not apply to the account.

A planning session can be requested by the external auditor, Anthem's Customer Audit Services or the PAO audit coordinator to review the audit scope and objectives and discuss the audit timeline and process.

▪ Pharmacy - Client Audit Limitations

- Approval for an audit will be based upon various business factors, including but not limited to the type of audit, the auditing organization, the contractual basis for the audit, and whether the scope of the audit is reasonable.
- The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit.
- An audit will generally be limited to no more than 250 randomly selected claims and must be free of bias, influence or conflict of interest. Samples sizes in excess of 250 claims may be permitted by Anthem, subject to Anthem's approval.
- Anthem will not allow an audit to be conducted by auditors working on a contingency fee basis or a concurrent/pre-payment basis.
- An account may conduct an audit once for any given period; the same period cannot be audited twice. The audit may only relate to claims processed during the current or immediately preceding contract period.
- The contract period may be a calendar year or benefits year, as outlined in the ASO Agreement.
- No more than one audit for a particular account shall be conducted during a calendar year. Requests for additional audits will be considered for approval (with potential fee implications) on a case-by-case basis.
- For financial guarantee audits, based on an aggregated guarantee, the audit may not commence until the immediately preceding contract year has completed.

- Clients may not audit contracts with vendors, providers including pharmacies or pharmaceutical manufacturers, which are considered proprietary and confidential.
- Anthem will not agree to requests for reimbursements based on the use of extrapolation methodologies to infer errors in a population of claim payments based upon the error rate in a sample drawn from that population. No adjustments will be made based on any extrapolation of known errors in the statistical sample.

Access to PBM Pharmacy Claims System and Pharmacy Information

The external auditor may *not* contact Anthem's PBM and will *not* be given access to the pharmacy claims processing system. Audit conducted onsite at the PBM are not permitted.

In all instances, PAO will provide claims and benefit information to the auditor. It is the responsibility of the audit coordinator to ensure that data is released to external auditors in accordance with HIPAA Privacy and Security requirements, as well as other applicable state and federal privacy laws. The group, external auditor, Anthem Customer Audit Services, PAO and PBM are required to comply with HIPAA and other relevant laws in handling any protected health information and agree to only use and/or disclose the minimum amount of PII and PHI necessary to perform the audit in accordance with these requirements.

Pharmacy Data Extracts

If PAO releases a claim extract, the extract will be based on the current NCPDP format and a data dictionary that have been developed for pharmacy claims. The included data elements are sufficient for the sample selection as well as automated testing. Requested data elements that are not included on the list are subject to approval by PAO prior to the audit. If approved, it may take up to an additional 20 business days to deliver the customized claims extract file.

For inquiries to the PAO team, the external auditor must ensure that the claims sample includes adequate information for PAO and the PBM to pull the required claims and benefit documentation. The sample must include the following data elements:

- Rx Number
- Date of Service

- Member Name
- Member Date of Birth
- Amount Paid
- Health Care ID (HCID)
- Claim Reimbursement Number

Standard Documentation Package and Timeframe for Providing Data

Documentation mutually agreed upon between PAO and the external auditor shall be produced. Such documentation may include an electronic version of the claims extract and copies of pharmacy claims for the audit sample. Other information such as benefit design or formulary information may be provided electronically through a secure and mutually agreed upon method.

Anthem requires a minimum of 20 business days to provide requested documentation for an audit. However, this timeframe may vary based upon the sample size, the type of documentation requested, and the age of the documentation. Audit documentation is pulled on a first in first out basis. The external auditor will be notified of any delays in providing documentation.

Audit Inquiries

The PAO audit coordinator will be the external auditors' primary contact during the pharmacy audit and will coordinate activities with other functional areas within PAO and the PBM as needed. All requests from the external auditor for information (claim data, benefit information, etc.) must be submitted in writing to the PAO audit coordinator. Issues or questions the external auditor may have during audit testing should also be submitted to the PAO audit coordinator.

Inquiries from the external auditor to be received by the PAO audit coordinator within 60 business days of providing the claims data and documentation to the external auditor. Failure by the external auditor to respond within 60 business days or to notify of a delay or request an extension may result in IngenioRx closing the audit. Re-opening of the audit will be determined by the Account Manager assigned to the client

• Audit Reports and Responses to Findings

PAO requires the external auditor to provide a copy of audit findings prior to the final audit report being released to the group. PAO also requires the opportunity to review and respond to each audit finding prior to the final audit report being released. The findings must be received within 30 days after audit testing is completed. PAO will provide a written response to all audit findings within the timeframe agreed upon by the external auditor and PAO audit coordinator.

PAO requests the external auditor also provide a copy of the final audit report at least 15 business days before the final report is issued to the client. The report will be reviewed for accuracy and a response will be provided if appropriate. A copy of the PAO response to the final audit report must be included, in its entirety, in the final audit report issued to the client.

• Claim Errors and Reimbursement

Claim or benefit errors identified during the audit must be confirmed by the PAO audit coordinator. If confirmed, PAO will work with the PBM to promptly correct the error. Reimbursement requests must be based on actual claims. PAO will not recognize requests for reimbursements based on the use of extrapolation methodologies. Any claim payment or benefit errors discovered during the audit shall not be extrapolated to include claims with dates outside the audit period or claims that are outside the scope of the audit.

In the event a discrepancy is found to be accurate, an impact analysis will be run to identify the total number of claims impacted for the audit period and to determine the final amount owed to the group and/or member(s). The PAO auditor coordinator will notify Anthem Customer Audit Services and/or the external auditor of the final impact and reimbursement will be arranged. Reimbursement will be made in the appropriate matter, which may include but is not limited to claim adjustments or in the form of a credit on the client's invoice. The form of reimbursement will be determined by Anthem.

• Implementation Audits

PAO will perform implementation audits contingent upon meeting the requirements outlined in the Anthem's Pharmacy External Group Audit Policy section of this Audit Policy.

Implementation audits are performed prior to the effective date of an account's contract period to test readiness for claims processing by verifying the accuracy of benefit coding and/or eligibility information in the system.

Any requests for exceptions to the below policy must be submitted with the confirmation of intent to audit. The request will be reviewed, and the auditor notified if Anthem agrees to the exception.

- A signed confidentiality agreement must be received by Anthem from the auditor prior to the designated audit commencement date.
- Implementations not involving benefit changes will be ineligible for an implementation audit. (Example: An implementation audit for an account adding new subgroups without any changes to the current benefit structure will not be accommodated.)
- A scope letter must be submitted to PAO once the intent to audit is confirmed.
- Benefit sign-off from the client is required 90 days prior to the benefits plan effective date before an implementation audit will be scheduled. Any changes to benefits after the initial sign-off may lead to a postponement and possible cancellation of the audit.
- PAO benefit coding and internal testing must be completed before preparation work for the implementation audit can begin.
- Implementation audits for new business will be scheduled based on a mutually agreeable time frame established by PAO and auditor. Missed timelines may lead to a postponement and possible cancellation of the audit.

- PAO will schedule implementation audits prior to the account's effective date where possible. These are scheduled on a first in, first out basis. Implementation audits require test cases to be submitted to PAO at least 90 days prior to the benefit effective date. Test cases not received 90 days prior to the effective date may lead to postponement or possible cancellation of the audit.
- PAO maintains a set of 23 different test claim scenarios (test bed) covering a broad range of services for implementation audit use. The auditor will select specific test scenarios from the test bed for review. There will be a limit of 100 test scenarios per plan up to a maximum of 275 claims across all plan designs.
- Pricing guarantees are on an aggregate basis. Pricing cannot be tested at a claim level and requests to test claim pricing will not be permitted during an implementation audit.
- Following the audit, a correction plan (including timeline) will be provided for any issues identified during the audit.
- Requests to conduct an implementation audit using test claims after the client's benefit plan is effective cannot be accommodated. A self-insured client can elect to conduct a Pharmacy Client Audit using paid claims data as described previously. If there are specific benefit types that cannot be audited because no claims have been submitted, Anthem will consider a request for a small sample (20 claims or less) of test claims to confirm benefit set up. The auditor will need to request this exception in writing.

- **Anthem's Clinical Audit Policy**

Anthem will cooperate fully, professionally, and efficiently with accounts requesting clinical (utilization management, case management, disease management) audits. An account shall have the right to conduct such audits on Anthem's premises, during regular business hours at its own expense to the extent such rights are reserved in the account's contract with Anthem. On-site clinical audits, clinical readiness assessments (conducted pre- or post-implementation), site visits and culture training must pertain to operational processes and not to individual Anthem associates. The purpose will be to assess the clinical and behavioral outcomes of Anthem's efforts, not the capabilities of individual associates. The scope of the audit, including the level of account participation, shall be agreed to in writing by the parties prior to the commencement of the audit.

If an account chooses to use a third-party/external auditor to conduct an audit, such auditor must be mutually acceptable to the account and Anthem. An auditor or consultant must execute a confidentiality agreement with Anthem pertaining to the protection of Anthem's proprietary or confidential information prior to conducting an audit, if not already on file.

The policy below will apply to clinical audits, clinical readiness assessments, site visits and culture training conducted by an account, a third party engaged by an account, or both.

- **Anthem Data Files**

In order to facilitate an audit, Anthem may release confidential information which includes, but is not limited to, case identification numbers, triggers, diagnoses, admission dates and other unique case identifiers and Anthem business, technical and proprietary information. This confidential information is permitted to be used only in connection with the audit and shall not be combined with data from other sources or in any way be aggregated into a third-party data base for use outside the permitted audit. The party to whom the confidential information is released must take reasonable administrative, physical and technical steps to safeguard it and prevent unauthorized disclosure of it to third parties and shall be solely responsible for the safekeeping of all data in its possession. In any authorized use of the data, the auditor may only release the confidential information in an aggregated de-identified form so as to avoid identification of any member. Any confidentiality and non-disclosure provisions contained in the account's contract with Anthem shall apply to clinical audits.

- **Access to Anthem Associates**

In an effort to remain focused on engaging members and improving health outcomes it is imperative that we avoid disrupting operational activities of the frontline clinicians. Therefore, Unit Directors and/or Audit Liaisons will coordinate and manage auditor and account requests for onsite visits and clinical reviews. Clinical Managers/Audit Liaisons will serve as the subject matter experts and participate in all audits, readiness assessments and site visits. For Integrated Health Model (IHM) clients, auditors can request access to frontline staff which may or may not be granted based on Anthem leadership discretion. If granted, it will be for case/clinical scenario presentation purposes only and may not include assessment of the individual associates. For Coordinated Care Model (CCM) clients, auditors will only have access and contact with Anthem's Clinical Managers and/or Audit Liaisons for case/clinical scenario presentations.

It is important that Anthem consistently manage to its clinical audit policy with regard to access to frontline clinicians in any of its units. The success of an on-site clinical audit, readiness assessment, site visit or culture training is important to its business. As such, clinical managers will support the clinical audit process and represent the processes specific to the overall strategy of Anthem Care Management.

- **Scheduling and Logistics - *Clinical Audits***

Auditors are required to provide at least 60 calendar days advance notice and are to submit, in writing, a detailed audit scope document to include the date of the visit, a list of attendees (including individuals representing the account, if applicable), objectives, clinical scenarios to be reviewed and any requests for system reviews and/or recorded calls including the number of recorded calls to be reviewed and the types of cases that will be assessed. The total number of cases to be reviewed, inclusive of all programs being evaluated, will not exceed a total of 30 cases or calls or combination of the two unless approved by Anthem leadership. The audit scope document should clearly specify how long the clinical review will take. The on-site portion of the clinical audit will last no longer than two (2) business days. The auditor will appropriately staff the engagement and is responsible for all of its expenses. It is advantageous to resolve any questions while the auditors are on site, and auditors should staff accordingly. An appropriate workspace will be arranged for the

auditors while they are on site. Auditors on site should plan to work during Anthem's standard business hours of operation of 8:00am – 5:00pm.

All cases will be reviewed in the presence of a Clinical Manager and/or an Audit Liaison supporting the process. The Anthem Clinical Management Team/Audit Liaison will conduct all systems demonstrations. Cases will be reviewed on the system based on a demonstrated necessity for such a review.

The audit may include the monitoring of member calls for quality purposes. As technology allows, Anthem will support the monitoring of previously recorded calls. The auditor may only listen to calls for the specific account being audited. The call associated with the case will be selected by Anthem.

The audit scope may also include a walkthrough or tour of the unit or units where clinical services are performed. Anthem will arrange such tours for the auditor. Confidentiality agreements may be required for such tours if agreements are not already in place.

- **Scheduling and Logistics - *Clinical Readiness Assessments***

Prior to or right after an account implementation, auditors may request an on-site clinical readiness assessment. Auditors are required to provide written 60 calendar day notice and will submit a clinical readiness assessment scope document outlining the purpose of the assessment and details of desktop, website and clinical scenario review. If clinical scenarios are to be used, they must be provided to the Anthem clinical team at least 30 calendar days in advance of the on-site. The on-site portion of an audit will last no longer than one (1) business day. For smaller accounts we recommend that the audit assessment occur at least one month following initiations so that cases and recorded calls will be available to assess.

- **Scheduling and Logistics - *Account Site Visits***

Account site visits may occur yearly and will be hosted by the Anthem Clinical Management team. Prior to the site visit, the auditor should request the participation of Anthem's frontline clinicians. The request will be reviewed by Anthem leadership and approved or denied at leadership's discretion. Auditors and accounts may ask to participate in Medical Director facilitated meetings. Anthem will review such requests individually and will allow participation as appropriate. If participation is allowed, auditors and accounts may observe grand rounds, mixed rounds, and/or curbside rounds (National ASO Integrated Health Model accounts only). Follow-up items and next steps will be addressed by the Clinical Management Team in a closing session.

- **Scheduling and Logistics - *Account/Vendor Culture Training***

Account/vendor culture training for frontline clinicians may occur yearly. The objective of these meetings will be information sharing. The account and/or external vendor partners will provide information to frontline clinicians on the account's culture, healthcare strategy, employee wellness programs, etc. The account may ask the frontline clinicians general clinical questions. The intent of these questions should be to get a general feel for how responsive the team is and not to assess the performance of an individual clinician.

- **Account Participation in Clinical Audits**

An account may express interest in participating in an on-site review conducted by an auditor or in conducting its own audit. Anthem will work with the account in that regard if the account has a contractual right to such an audit. The type of information shared will vary based on whether the account's plan is insured or self-funded, and the purpose and necessity of the audit.

Self-Insured Accounts (ASO)
HIPAA recognizes an organizational distinction between a Group Health Plan sponsor and the Group Health Plan. Individuals participating in a clinical audit must represent the Group Health Plan (approved individual(s) within the benefits administration department) and/or medical staff providing a service to the Group Health Plan and not the plan sponsor. A confidentiality agreement and a Group Health Plan Representative Designation Form must be executed prior to the commencement of the clinical site visit.

During audits the team will receive a predetermined list of cases and the defined template for the assessments. If arranged in advance, cases can be reviewed on the system based on a demonstrated necessity for such a review. The Group

Health Plan must submit a PHI Request Form at least 60 days in advance of any audit in order to review cases on the Anthem system. The Anthem Clinical Manager or Audit Liaison will conduct the system demonstration and case review. Auditors and accounts will be granted system access only with approval from the Clinical Manager and all system reviews will occur with Anthem supervision.

The audit scope may include the monitoring of Group Health Plan member calls for quality purposes. Anthem will support the monitoring of previously recorded calls as technically feasible. The auditor or account may provide the parameters for recording.

The audit scope may also include a walkthrough or tour, where there is a clinical unit available, of the unit or units where clinical services are performed. Anthem will arrange such tours for the auditor. The auditor will observe the activities of the unit as a whole but will not be allowed to watch any specific frontline clinician update individual cases. The Group Health Plan representative may only tour the unit if it is dedicated to the account. Confidentiality agreements may be required for such tours if agreements are not already in place.

Fully Insured Accounts
Anthem will work with a fully insured account expressing interest in a clinical audit if the account has a contractual right to such an audit. Individuals participating in the review must represent the Group Health Plan. A confidentiality agreement and a Group Health Plan Representative Designation form must be executed prior to the commencement of the site visit. In addition, if the Group Health Plan requests to review cases that contain PHI, the Group Health Plan must submit a PHI Request Form at least 60 days in advance of the audit.

During audits the Clinical Manager or Audit Liaison will receive a predetermined list of cases and the defined template for the assessments. If arranged in advance, cases can be reviewed on the system based on a demonstrated necessity for such a review. The Group Health Plan must submit a PHI Request Form for consideration at least 60 days in advance of any audit in order to request a review cases on the Anthem system. The Clinical Manager or Audit Liaison will conduct any approved system demonstration and case review.

The policy for listening to phone calls is as described above for self-insured accounts except that they apply to the auditor only. Under no circumstances will the Group Health Plan representative be allowed to listen to calls.
The audit scope may also include a walkthrough or tour of the unit or units where clinical services are performed. Anthem will arrange such tours for the auditor. The auditor will observe the overall activities of the unit but will not be allowed to watch any specific frontline clinician update individual cases. The Group Health Plan will not be allowed to participate in any tour or walkthrough. Confidentiality agreements may be required for such tours if agreements are not already in place.

▪ Legal and Other Limits on Disclosure of Information

Anthem uses and discloses member PII and PHI only in accordance with applicable law and its Corporate Privacy Policy and operating procedures. The policy provisions support Anthem's compliance with the HIPAA Privacy rules, as well as other state and federal privacy laws. The policies may be amended from time to time, in accordance with applicable federal and state privacy laws and regulations. The account, auditor, and Anthem are all required to comply with HIPAA and other relevant laws in handling any PHI and agree to only use and/or disclose the minimum amount of such PHI necessary to accomplish the purpose of the audit, in accordance with these requirements. These parties must also agree to protect the confidentiality of this information and ensure that it is properly disposed of or retained in accordance with applicable law and/or Anthem's record retention policies and procedures once auditing activities have been completed.

No documents or copies of documents containing PHI or PII may be removed from Anthem's facilities or shared electronically with auditors, consultants, or clients. In addition, no documents or copies of documents considered confidential to Anthem may be removed from Anthem's facilities or shared electronically with auditors, consultants, or clients.

During the audit, if questions or concerns arise regarding the confidentiality of any information, the Clinical Manager or Audit Liaison will contact Anthem's Legal Department and/or the Privacy and Security Office for clarification before the information is released.

▪ Exception Process

Special circumstances may require deviations from this policy. These may be approved by clinical business owner(s) with appropriate levels of authority as circumstances warrant. Such business owner will require a detailed written description of the audit scope. The clinical business owner will review the scope, consult with Anthem Legal, Account Management,

and Clinical Management to evaluate the risks and reach a decision. The decision will be communicated in writing to the Clinical Manager and/or Audit Liaison and the Account Management team. If the decision is to deny the exception, the Account Management team will convey the denial message to the account and will notify the Clinical Manager and/or Audit Liaison of such in writing. Following such written notification, the Anthem Account Management Team will contact the auditor to convey the message that the audit request has been denied. The approval of an exception will be communicated to the auditor immediately upon notification.

DRAFT REPORT
(SUBJECT TO REVISION)

Reporting to
MISSOURI CONSOLIDATED HEALTH CARE PLAN

Comprehensive Healthcare Consulting Engagement

In Connection with the Anthem Blue Cross and Blue Shield's Administration of the Missouri Consolidated Health Care Plan

For the Year Ended December 31, 2020

TMDG
Healthcare Assurance
& Risk Consulting

CONTENTS

SECTION I: STATEMENT OF CONFIDENTIALITY

This report is intended solely for the information and use of the Missouri Consolidated Health Care Plan and Anthem Blue Cross and Blue Shield and is not intended to be and should not be used by anyone other than those specified parties. Distribution of other information related to this engagement will be released with similar restrictions.

SECTION II: ACKNOWLEDGEMENTS

We would like to extend our appreciation to the Missouri Consolidated Health Care Plan and the employees of Anthem Blue Cross and Blue Shield for their professionalism, dedication and effort to ensuring the attached document represents a complete, thorough, and accurate review.

SECTION III: EXECUTIVE SUMMARY

TMDG

January 6, 2023

To the Missouri Consolidated Health Care Plan
Jefferson City, MO

The Plan Sponsor of the Missouri Consolidated Health Care Plan (the Plan) engaged us to perform a comprehensive healthcare audit of the health benefits administered by RightCHOICE Managed Care, Inc. d/b/a Anthem Blue Cross and Blue Shield (TPA) on behalf of the Plan pursuant to an Administrative Services Agreement (ASA) for the claims processed during the period from January 1, 2020 through December 31, 2020.

Our engagement was conducted in accordance with The Statement on Standards for Consulting Services and the Code of Professional Conduct issued by the American Institute of Certified Public Accountants.

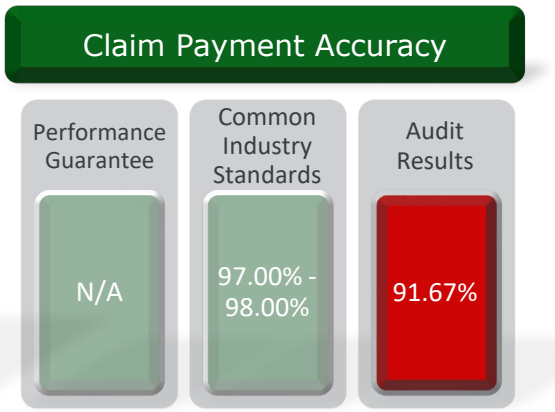
The engagement included an operational review, statistical claims audit, focused claim audits, and electronic claims review. A high level executive summary is provided below. The details which support the findings and conclusions follow this section of the report.

Performance Compared to Industry Standards and Performance Guarantees

Independently measuring the claims quality performance metrics of the TPA on a routine basis against industry standards and performance guarantees is an important indicator of how the TPA is performing.

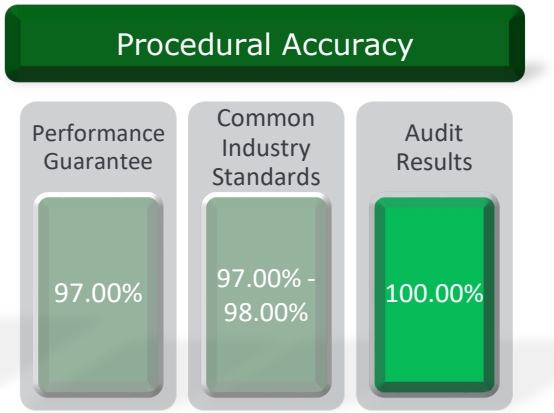
Claim Payment Accuracy

The claim payment accuracy guarantee measures the number of incidences the TPA processed a claim accurately (i.e., did not result in a payment error) during the measurement period. The audit result demonstrates the TPA is below industry norms and may indicate a gap in its quality control initiatives or a heavily manual claims process. This gap is further supported by the operational review findings in the areas of eligibility processing, duplicate claims, and application of benefits. Further discussions with the TPA are warranted in this area.



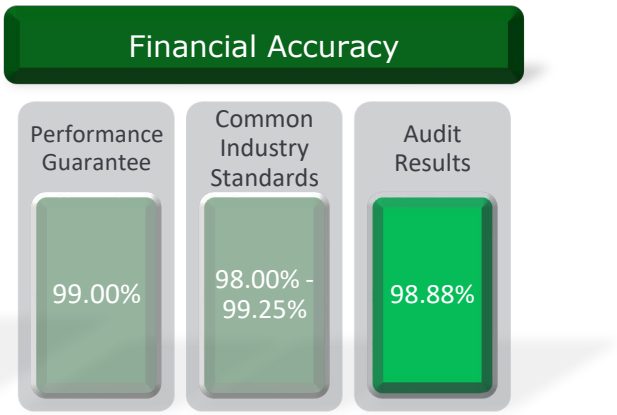
Procedural Accuracy

The procedural accuracy guarantee measures the number of incidences the TPA processed a claim accurately (i.e., failed to follow its policies and procedures but did not result in a financial error) during the measurement period. The audit result demonstrates the TPA is well within industry norms. It supports the fact that the TPA has a highly automated claims process that captures provider billing information properly and its payment rules are being adhered to.



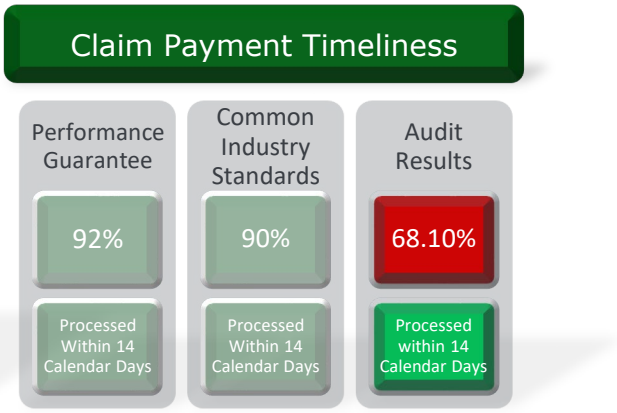
Financial Accuracy

The financial accuracy guarantee measures the dollar value of the claims the TPA processes accurately during the measurement period. The audit result demonstrates the TPA is well within industry norms. It would support the conclusion that, although the TPA may have gaps in its quality control initiatives those gaps are not readily apparent when it comes to high dollar claims.



Claim Payment Timeliness

The claim payment timeliness guarantee measures how timely non-investigated medical claims are processed. The audit result demonstrates the TPA did not meet the performance guarantee.



Operational Evaluation

The operational evaluation measures the structure, staff, and claim adjudication process of the TPA to its peers in the industry while considering the size and complexity of the Plan. The following table summarizes the results of our testing in eight (8) key operational categories selected by the Plan Sponsor.

Operational Evaluation

The operational evaluation depicts a properly structured TPA organization with system capabilities and claims adjudication processes sufficient to administer the Plan. However, we identified one or more weaknesses that require corrective action in the areas of eligibility/benefit determination; claims processing procedures and controls; and cost containment policies and procedures. These limitations include both systemic and non- systemic issues that directly resulted in claim payment overpayments during the evaluation.

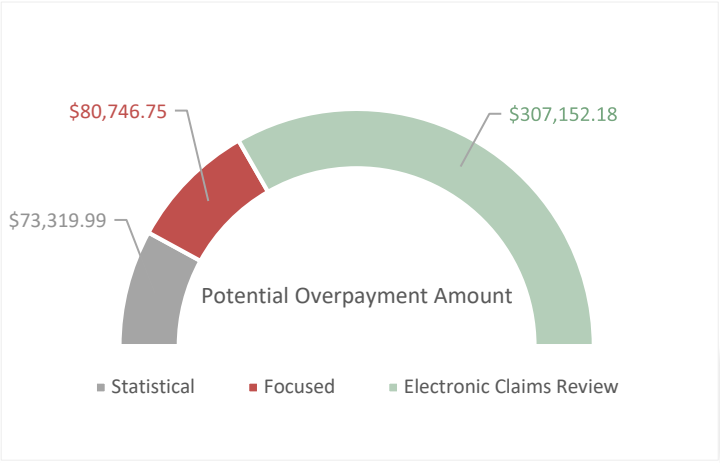
Operational Evaluation Category	Rating
System Capabilities	✓
Claims, Receipts, Coding, and Data Entry	✓
Case Registration and Case Management	✓
Eligibility/Benefit Determination	!
Claims Processing Procedures and Controls	!
Cost Containment Policies and Procedures	!
Financial Process	✓
Quality Review Programs	✓

Rating	Description
✓	No findings or recommendations were noted in this area.
!	Findings and recommendations were noted in this area.

Overpayment Recovery Opportunities

Overpayment Recovery Opportunities

The engagement identified $461,218.92 in potential overpayment recover opportunities for the Plan in the following areas: statistical claims audit findings - $73,319.99, focused claims audit findings - $80,746.75, and electronic claims audit findings - $307,152.18. (The electronic claims audit findings were reduced by $5,179.29 for errors that were also captured in other sections of the report.) The TPA agreed with $69,095.94 of the errors identified in the statistical and focused claims audit sections of the report and chose not to review the electronic claims audit findings.



Next Steps

This report concludes are engagement for Missouri Consolidated Health Care Plan. Based on the results of our evaluation, we would recommend the Plan Sponsor meet with the TPA on a routine basis, no less than monthly, to –

1. Monitor the progress of the overpayment determination and recovery process.
2. Monitor the corrective action of the TPA relating to weaknesses that were identified with the system capabilities; eligibility/benefit determination; and claims processing procedures and controls.
3. Monitor the quarterly performance guarantees particularly the claims payment accuracy guarantee.

Conclusion

This report concludes our comprehensive healthcare audit of the health benefits administered by the TPA on behalf of the Plan. Our results indicate that the TPA possesses both the competency and capacity to properly administer benefits of the Plan, but we note that there are areas where improvements and corrections should be made.

Except for the deficiencies noted in the report, based on the limited procedures performed, we did not find evidence that the financial or procedural accuracy relative to the TPA's health claims administration for the period under review significantly deviated from industry standards; however, the claim payment accuracy and claim payment timeliness were below our expectations. We appreciate the opportunity to conduct the healthcare consulting services for the benefit of the Missouri Consolidated Health Care Plan and would be pleased to further assist you in addressing any concerns you may have.

Disclaimer

It is important to note that the conclusions rendered in this report were based, in part, from results gathered from statistically valid sampling techniques, which are subject to sampling risk which arises from the possibility that, when restricted to a sample, the reader's conclusions may be different from the conclusions that would be reached if the test was applied in the same way to all items in the population.

We were not engaged to and did not perform a financial statement audit of the claims processed by the TPA on behalf of the Plan, the objective of which would be the expression of an opinion on the objectives previously defined. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the use of the Missouri Consolidated Health Care Plan and the TPA and should not be used by those who have not agreed to the procedures and taken responsibility for the sufficiency of the procedures for their purposes.

Baltimore, Maryland

SECTION IV: OPERATIONAL REVIEW

The operational review was conducted remotely with the TPA's subject matter experts. The remote fieldwork commenced Monday, June 20, 2022 and was concluded on Friday, June 24, 2022.

Scope

The operational review covered the health benefits administered by the TPA on behalf of the Plan pursuant to its respective ASA Contract for claims processed during the period from January 1, 2020 through December 31, 2020.

Objective

The operational review engagement objectives were designed by a representative of the Plan Sponsor, with our assistance, to:

(a) Determine if the TPA's claims operational procedures and controls are working as intended;
(b) Determine if the quality of the TPA's claim processing is consistent with contracted performance requirements and healthcare industry best practices; and
(c) Identify where performance gaps exist and how the Plan can work with the TPA to strengthen administration by improving quality and reducing cost.

Procedures

We created an operational engagement questionnaire and submitted it to the TPA to evaluate its administrative capabilities. This questionnaire was separated into the following eight (8) Operational Categories: systems capabilities; claim receipts, coding and data entry; case registration and case management; eligibility and benefit determination; claims processing procedures and controls; cost containment policies and procedures; financial process; and quality review programs. This questionnaire contained questions related to out-of-network claims (e.g., shared savings program – leased networks, usual and customary pricing, and negotiated rates), administration of specialty drugs, and accumulation of patient liability in the case registration and case management, claims processing procedures and controls, and the cost containment policies and procedures categories. The questionnaire included specific questions regarding the TPA's claims payment system, override procedures, the TPA's ability to identify duplicate claims, subrogation, determination of medical necessity for the specific services specified by MCHCP, the TPA's internal audit system, and refund activity.

The TPA's responses to the questionnaire were confirmed by us through meetings, follow up interviews with its Subject Matter Experts, as well as comparisons to the results of the detailed claims test work performed during the statistical claims audit, focused claim audits and electronic claims review.

Findings, Observations and Recommendations

System Capabilities

Observation No. 1 – Auto-Adjudication Rate

Condition: A TPA's auto adjudication rate often provides insight into its claims processing capabilities. The lower the rate is as compared to the industry standard, the more likely the claims processing system is: (a) unsophisticated; (b) not utilized to its fullest potential; and/or (c) an indication that the Plan has a non-standard benefit structure, which does not easily lend itself to auto adjudication. The higher the rate is as compared to the industry standard, the more likely the claims processing system has sacrificed quality in favor of automation, or the Plan's benefit design is very standard, which does lend itself to auto adjudication.

Observation: In its response to our questionnaire, the TPA reported an auto adjudication rate for the administration of the Plan during the engagement period of approximately 84%, which is within industry norms. We noted this is below the TPA's book of business auto adjudication rate of 88%.

Eligibility/Benefit Determination

Finding No. 1 – Incorrect Member Liability Accumulation

Condition: The Plan limits member out-of-pocket expense to the following:

Plan		Deductible		Out-of-Pocket	
		INN	OON	INN	OON
PPO 750 Plan	Individual	$750	$1,500	$2,250	$4,500
	Family	$1,500	$3,000	$4,500	$9,000
PPO 1250 Plan	Individual	$1,250	$2,500	$3,750	$7,500
	Family	$2,500	$5,000	$7,500	$15,000
HSA Plan	Individual	$1,650	$3,300	$4,950*	$9,900
	Family	$3,300	$6,600	$9,900	$19,800

**If there are other family members in this plan, the overall family out-of-pocket must be met. However, any individual family members need only incur $8,150 in in-network out-of-pocket before the plan begins paying 100% for that individual.*

For the PPO Plans, the Plan will pay claims once a family member meets their own individual deductible and/or the family deductible has been met.

For the HSA Plan, if two (2) or more family members are covered, the overall family deductible must be met before the Plan begins to pay.

Finding: During the course of the engagement, we identified 10 members whose deductible and/or out-of-pocket maximums were exceeded in amounts ranging from approximately $120 to more than $44,200.

Additionally, during our electronic claims review, we identified 1,069 instances in which it appears the TPA exceeded the deductible and/or out-of-pocket maximum. The results of our review are as follows:

Description	Number of Members	Potential Net Plan Underpayments
HSA Plan Family Accumulator	15	($2,971.24)
HSA Plan Individual Accumulator	3	($619.68)
PPO 750 Plan Family Accumulator	206	($49,821.11)
PPO 750 Plan Individual Accumulator	406	($134,164.14)
PPO 1250 Plan Family Accumulator	91	($77,971.63)

Description	Number of Members	Potential Net Plan Underpayments
PPO 1250 Plan Individual Accumulator	348	($200,829.06)

Recommendation: We recommend that a representative of the Plan Sponsor meet with the TPA to discuss the reasons for these errors and the corrective action that will be put into place to correct this matter moving forward.

Claims Processing Procedures and Controls

Finding No. 2 – Duplicate and Overlapping Payments

Condition: The TPA has prepayment edits in place to mitigate the risk of duplicate and overlapping claims payments.

Finding: During our engagement, we sampled and tested 20 claims we flagged as potential duplicate payments within the paid claims data provided for the engagement. Of the 20 claims sampled, we verified that 10 were actual duplicate payments. We investigated the root cause of the sampled errors and was unable to determine any of the errors related to a systemic error condition. For the majority of the instances, the error was caused by a manual override of a system edit.

During our electronic claims review, we identified 205 instances in which it appears the TPA paid for duplicate/overlapping services. The results of our review are as follows:

Description	Number of Claims	Potential Net Plan Overpayments
Potential Duplicate Professional Claims	153	$9,323.47
Potential Duplicate Facility Claims	52	$26,548.62

Recommendation: We recommend that a representative of the Plan Sponsor request that the TPA review the duplicate claim payment errors we identified during the focused claims audit to determine the root cause and nature of that error. Based on the nature of the problem, we would expect the TPA to develop a corrective action plan to address the matter. Additionally, we would recommend the Plan Sponsor expand the engagement test work to include additional testing in order to maximize the recovery opportunity for these claims.

Finding No. 3 – Administration of Co-Payments

Condition: The Plan is designed to apply fixed dollar co-payments for certain covered services.

Finding: During the course of the engagement, we identified several issues related to the administration of co-payments as described below:

1. Failed to waive emergency room co-payment for emergent medical conditions;
2. Incorrectly applied a co-payment instead of deductible and/or coinsurance; and
3. Failed to apply a co-payment.

Recommendation: We recommend that a representative of the Plan Sponsor request that the TPA review the co-payment errors we identified to determine the root cause and nature of that error. Based on the significance of this issue, we would expect the TPA to develop a corrective action plan to address the matter.

Finding No. 4 – Payment of Claims for Non-Covered Services and/or Plan Limitations

Condition: The Plan benefits contain a list of general exclusions and limitations, which contains different services and scenarios for which no benefits will be paid by the Plans.

Finding: We utilized rule based algorithms to identify and electronically evaluate claim payments related to certain general plan exclusions and limitation to assess the risk of financial loss to the plan due to claim payment errors related to this area. The testing utilized the claim data set that was provided for this engagement, which contains limited information about each claim. Our evaluation identified numerous instances of claim payment anomalies which if investigated further by the TPA might reveal a claim payment error. The claim payment anomalies totaled approximately $266,000 with the most significant dollars occurring in the following four (4) categories: educational or psychological testing; non-covered medical supplies; eye glasses or lenses; and maxillofacial surgery. We performed additional testing on 20 claims and determined eight (8) were in error. However, the TPA agreed to only three (3) errors. It is more than reasonably possible that upon further review of the remaining claims in question, the TPA, as well as the Plan, would determine the vast majority of these claims were properly paid.

Recommendation: We recommend the Plan Sponsor consider providing a sample of the largest claims (e.g., those over $5,000) to the TPA for further investigation. We would also recommend that the TPA continue to evaluate the four (4) categories where the majority of the financial risk to the plan exists for future processing.

Finding No. 5 – Claim Payment Timeliness

Condition: One of the performance guarantees contained in the ASA contract with the TPA is for claim payment timeliness. The performance guarantee states that a minimum of 92% of non-investigated medical claims will be processed within 14 calendar days.

Finding: During the statistical claims audit portion of this engagement, we calculated the claim payment timeliness found within the statistical samples. Of the 216 statistical sample claims selected for review, 210 claims were considered non-investigated medical claims and included in the claim payment timeliness calculation. Of those 210 claims, 67 were processed more than 14 calendar days after the received date. This provides a timeliness processed percentage (i.e., claims processed within 14 calendar days of the received date) of 68.10%. With respect to the 14 calendar day processing requirement outlined in the performance guarantees, the TPA is below the performance guarantee standard and it appears 100% of the $100,000 penalty is due.

During our remote testing, the TPA provided the following statement regarding the claim payment timeliness issues identified: "*A backlog of claims had occurred in 2020 due to COVID-19. The client is aware of the delays and missed opportunity in meeting claim timeliness performance guarantees during 2020."*

We requested the claims inventory backlog as part of our questionnaire. The TPA responded that the backlog details are not included as part of its audit reporting.

On December 15, 2022, the Plan Sponsor provided the letter it issued to Anthem on May 20, 2021, which stated the following:

> After carefully reviewing your request for relief in the payout of the missed 2020 performance guarantees penalties due to Covid-19 operational impacts for claim timelines, written inquiries and average speed to answer. MCHCP can agree to suspend the collection of these three penalties. If Anthem meets or exceeds performance standards for these guarantees in 2021, then the 2020 suspended guarantee penalties will not be collected. Should Anthem not meet the three guarantee standards in 2021, MCHCP will agree to collect both the 2020 and

2021 penalties at that time. If this is acceptable by Anthem, we will notate the performance guarantees to reflect this agreement.

Recommendation: We recommend that a representative of the Plan Sponsor meet with the TPA to discuss the reasons for untimely processing of claims and the corrective action that will be put into place to correct this matter moving forward. We also recommend the Plan Sponsor assess whether Anthem met its performance guarantee metrics for 2021 and if the penalty for missing the 2020 metrics is due.

Cost Containment Policies and Procedures

Finding No. 6 – Coordination of Benefits (COB) with Medicare or Other Insurance

Condition: Coordination of benefits is designed to provide the insured with as much coverage as possible, while eliminating over-insurance, by setting forth guidelines to determine which plan will pay as primary payer and which will pay as secondary payer when an employee and/or dependent have a claim that is covered by more than one insurance policy.

Finding: During the course of the engagement we noted the following types of COB errors:

1. Incorrect COB Calculation
2. Incorrect COB Calculation – Paid Above Patient's Legal Obligation

It is important to note some of the findings related to the TPA failing to limit the Plan's allowed amount to the lesser allowed by either the primary carrier or the TPA.

Because of certain limitations placed upon the claims data set provided to us for this engagement by the TPA, we were unable to electronically evaluate the potential financial impact of these issues.

Recommendation: We recommend that a representative of the Plan Sponsor request that the TPA review the errors we identified to determine the root cause and nature of these errors. Based on the nature of the problem, we would expect the TPA to develop a corrective action plan to address the matter.

Financial Process

Observation No. 2 – Overpayment Recovery Reporting

Condition: Operationally driven overpayment claim transactions, such as provider contract loading errors, benefit loading errors and claim processing quality errors, are identified, evaluated, pursued, and recovered by the TPA during the overpayment recovery process. The TPA produces a quarterly overpayment recovery report which includes subrogation and COB recoveries as well as other overpayment type recoveries. Reimbursements for recovery typically appear on ASO billing statements received with each payment cycle. The TPA is not able to support an overpayment outstanding dollars report or an accounts receivable report.

Observation: For the engagement period, the TPA reported $4,917,764.32 in overpayments that were credited to the Plan. These overpayments related to corrected claim/updated billing from provider, incorrect billing, duplicate payment, provider audit, member policy/contract not in effect at the time of service, incorrect member policy number/group number, member cancelled, benefit loaded/configured incorrectly in system, services not covered per member benefits, not medically necessary, durable medical equipment, incorrect reimbursement rate, system pricing loaded/configured incorrectly, corrected pricing received from Host Plan, manual processing deductible error, copay/deductible/coinsurance, payee refunded payment, paid to wrong provider/payee, COB on the claim was either not applied or applied incorrectly, COB – commercial carrier primary, COB – Medical primary, COB – commercial carrier adjusted original payment, 60 days ITS home adjustment, and front end data entry error.

Conclusion

The following rating system has been created by us in an attempt to score the TPA's performance relative to our experience with other large, national administrators in the marketplace based on the results of the operational review. For the purpose of the rating system, mainstream performance represents the prevalent approach used by administrators, but does not necessarily meet the expectations of best practices.

The rating system is as follows:

1 = superior performance to mainstream performance
2 = comparable performance to mainstream performance
3 = below mainstream performance

Note: If circumstances warrant, a plus (+) or minus (-) will be added to the numerical rating to indicate performance that is either slightly higher or lower than the industry standard, but not sufficient to receive the next appropriate level of scoring.

Category	Rating
System Capabilities	2
Claims Receipts, Coding and Data Entry	2
Case Registration and Case Management	2
Eligibility/Benefit Determination	2-
Claims Processing Procedures and Control	2-
Cost Containment Policies and Procedures	2-
Financial Process	2
Quality Review Program	2

These findings will be combined with the results of the other three (3) phases of the engagement to form an overall conclusion about the quality of the TPA's administration of the Plan.

Disclaimer

It is important to note that the conclusions, which we reached above, are subjective in nature and are based on the number, severity and history of the individual findings that we identified within each of the operational categories tested. Therefore, someone with similar experience, background and history may have drawn a different conclusion about one (1) or more of the operational categories.

SECTION V: STATISTICAL CLAIMS AUDIT

The engagement fieldwork for the statistical claims audit was conducted remotely with the TPA. The remote fieldwork commenced Monday, June 20, 2022 and was concluded on Friday, June 24, 2022.

Scope

The statistical claims audit covered the health benefits administered by the TPA on behalf of the Plan pursuant to an Administrative Services Agreement (ASA) for the positive paid claims processed during the period from January 1, 2020 through December 31, 2020.

Objective

The statistical claims audit engagement objectives were designed by a representative of the Plan Sponsor, with our assistance, to measure and report the TPA's compliance with

(a) The Plan's contracted performance guarantees for Claim Payment Accuracy, Financial Accuracy, and Claim Payment Timeliness; also comparing results with industry standards and self-reporting to MCHCP; and
(b) Benefit design as noted in procedures below.

Claim Population

The TPA data file, as well as information within the TPA's response to our questionnaire, provided the following information related to the membership and medical claims processed during the engagement period.

Average Number of Covered Employees as of December 31, 2020	38,294
Average Number of Covered Lives	74,601

Provider Network Status	Number of Claims Processed	Total Billed	Total Allowed	Total Paid	Total Patient Liability
In-Network	916,130	$917,882,399.08	$340,924,550.43	$281,457,832.66	$57,409,099.05
Out-of-Network	18,722	$26,758,741.31	$6,634,794.02	$4,405,223.20	$2,108,528.33
	934,852	$944,641,140.39	$347,559,344.45	$285,863,055.86	$59,517,627.38

Procedures

The resulting sample claims population was subject to monetary unit sampling, which inherently stratifies the claims population for sampling. By utilizing this statistical sample technique, we were able to evaluate a relatively small number of claims to form a statistically supportable conclusion about all of the claims within the sample population during the period under review. The sampling plan was designed by us to achieve a 95% confidence level and 3% precision using an expected error proportion of 1%. This provided a sample size of 216 claims.

Claims tested in the statistical claims audit underwent a rigorous review by us in order to verify the following criteria:

1. The claimant was eligible on the date of service;
2. Critical claim data fields were populated appropriately by the TPA;
3. The record of necessary documents was obtained by the TPA;
4. The allowable amount was properly determined by the TPA;
5. Patient liability was properly determined by the TPA;
6. The claim was mathematically accurate; and
7. The payment was issued to the correct party.

The following procedures were performed:

1. Verified appropriate documentation to support the payment of the claim was on file;
2. Verified the eligibility of the claimant on the date of service matches the eligibility information maintained by the Third Party Administrator;
3. Verified that the requisite notification, preauthorization, and/or precertification for services are noted in the claims system, or that any applicable reduction of benefits and payment were applied;
4. Verified the coding of the procedure and diagnosis code on the provider's submitted bill matches the information on the claim processed by the TPA for payment;
5. Verified the negotiated fee arrangement for in-network providers and other applicable fee arrangements applied to the claim match the rate schedule contained in the claims system of the Third Party Administrator, or usual, customary, and reasonable (UCR) rates were properly applied, if applicable*;
6. Inspected the coordination of benefits information within the claims system to determine if the claim was properly coordinated or if the Plan was primary;
7. Verified third-party liability provisions were properly applied;
8. Verified plan benefits, limitations and exclusions were properly applied;
9. Verified patient liability (i.e., deductibles, co-payments, and coinsurance) were properly applied;
10. Verified the mathematical accuracy of the claim payment;
11. Verified the payment was issued to the correct party based on the information contained in the claims system or support provided by the Host Plan;
12. Examined the claims history to ensure the claim was not duplicated or involved overlapping services for the same member, by the same provider, on the same date of service; and
13. Verified the claim was processed in a timely fashion and in accordance with performance standards established.

Exceptions were segregated into financial and procedural errors. The resulting ratios, which are common claim quality metrics used by the TPA, were calculated as follows:

Claim Payment Accuracy

Claim Payment Accuracy represents the total number of claims processed without any errors (limited to financial errors) divided by the total claims processed, expressed as a percentage. The calculation of claims paid with an error is determined from auditing a statistically valid sample of claims paid during the engagement period. The formula to be utilized is as follows:

$$\frac{\text{Total number of claims in the sample} - \text{Total number of claims identified with a financial error in the sample}}{\text{Total number of claims in the sample}}$$

The common industry standard we have observed for this measure is between 97.00% and 98.00%.

Financial Accuracy

Financial Accuracy represents the sum of the absolute value of total dollars overpaid and the total dollars underpaid subtracted from the total dollars paid, divided by the total dollars paid, expressed as a percentage. Overpayments and underpayments are determined from auditing a statistically valid sample of claims paid during the period. The formula to be utilized is as follows:

$$\frac{\text{Total dollars paid in the sample} - \text{Total dollar (absolute value) amount of errors in the sample}}{\text{Total dollars paid in the sample}}$$

The common industry standard we have observed for this measure is between 98.00% and 99.25%.

Procedural Accuracy

Procedural Accuracy represents the total number of claims processed without a procedural error (e.g., coding errors and data entry errors). Claims containing a financial error are not considered an error for purposes of this measurement. The calculation of claims paid with a procedural error is determined from auditing a statistically valid sample of claims paid during the period. The formula to be utilized is as follows:

$$\frac{\text{Total number of claims in the sample} - \text{Total number of claims identified with a procedural error in the sample}}{\text{Total number of claims in the sample}}$$

The common industry standard we have observed for this measure is between 97.00% and 98.00%.

Claim Payment Timeliness

Claim Payment Timeliness is determined by subtracting the date on which a claim was received from the date it was processed, expressed in days. Additionally, only non-investigated medical claims are included in this calculation. The formula is depicted as follows:

$$\text{Date the claim is processed} - \text{Date the claim was received}$$

The performance guarantee is that a minimum of 92% of non-investigated medical claims will be processed within 14 calendar days.

The claim quality metrics used in this report, which calculate claim quality on a sample claim population basis, is generally accepted within the industry and is commonly used by the TPA for measuring and reporting performance guarantees. The alternative methodology, which the TPA also uses in place of this methodology, would be a measurement of claim quality on an extrapolated basis. Although both are acceptable reporting methodologies, we generally measure claim quality on a sample claim population basis because of the nature and limitations of the engagement.

We randomly selected 216 individual claim payments to obtain a statistically valid sample of claims processed by the TPA during the period from January 1, 2020 through December 31, 2020. Errors were segregated and categorized as financial and procedural errors. Each error was reviewed in detail by a representative of the TPA prior to finalizing our report.

Detailed Financial Findings

Sample Claim Number	Amount in Error Overpayment/ (Underpayment)	TPA Response	Description
18	($202.64)	Disagreed	Incorrectly Applied Patient Liability to Preventive Services
30	($530.00)	Agreed	Incorrectly Applied Patient Liability to Preventive Services
47	$56.12	Agreed	Failed to Apply Coinsurance
57	($250.00)	Agreed	Failed to Waive Emergency Room Co-Payment for Emergency Medical Condition
84	$1,296.67	Disagreed	Failed to Apply Deductible and Coinsurance - Incorrectly Applied a Co-Payment
99	$1,190.93	Agreed	Failed to Apply Coinsurance
101	$1,435.45	Disagreed	Failure to Apply Patient Liability – Incorrectly Applied COVID Benefits
105	$1,486.22	Disagreed	Failed to Apply Deductible and Coinsurance - Incorrectly Applied a Co-Payment
109	$3,154.07	Agreed	Incorrect Patient Liability Amounts Applied
111	$153.01	Agreed	Failed to Apply Coinsurance
113	$994.58	Agreed	Failed to Apply Coinsurance
121	$2,011.38	Disagreed	Failed to Apply Coinsurance
134	$4,262.13	Agreed	Incorrect Patient Liability Amounts Applied
137	$2,824.41	Agreed	Failed to Apply Coinsurance
142	($20,460.00)	Agreed	Incorrect Allowed Amount
143	$269.43	Agreed	Failed to Apply Coinsurance
146	$0.02	Agreed	Incorrect Deductible Amount Applied
169	$32,895.43	Disagreed	Failed to Deny Claims for a Member with No Coverage Under the Plan
169	$19,966.06	Disagreed	Failed to Deny Claims for a Member with No Coverage Under the Plan
176	$185.87	Agreed	Failed to Apply a Co-Payment

Sample Claim Number	Amount in Error Overpayment/ (Underpayment)	TPA Response	Description
201	$1,138.21	Agreed	Failed to Apply Coinsurance

The error identified on this claim is considered out-of-sample. Therefore, the amount will not be included in the total financial errors when calculating the statistical claims audit results.

Procedural Findings

There were **no** procedural errors identified.

Conclusion

The following conclusions were drawn from our sample test work, which includes all of the detailed financial and procedural errors reported above, regardless of whether the TPA has agreed with those errors.

Claim Payment Accuracy

Of the 216 claims selected for review, 18 contained financial errors. This provides a claim payment accuracy rate in our sample of 91.67%, which is below the common industry standard we have observed.

Financial Accuracy

Of the 216 claims selected for review, 18 contained financial errors. This resulted in an absolute financial error in the sample population that totaled $74,063.93. This provides a financial accuracy in our sample of 98.88%, which is within the common industry standard we have observed.

Procedural Accuracy

Of the 216 claims selected for review, none contained a procedural error that did not result in a financial error. This provides procedural accuracy rate in our sample of 100.00%, which is within the common industry standard we have observed.

Claim Payment Timeliness

Of the 216 claims selected for review, 210 claims were considered non-investigated medical claims and included in the claim payment timeliness calculation. Of those 210 claims, 67 were processed more than 14 calendar days after the received date. This provides a timeliness processing percentage (i.e., claims processed within 14 calendar days of the received date) of 68.10%. With respect to the 14 calendar day processing requirement, the TPA is below the performance guarantee standard.

These findings will be combined with the results of the other three (3) phases of the engagement to form an overall conclusion about the quality of the TPA's administration of the Plan.

Disclaimer

It is important to note that the statistical sampling is subject to sampling risk, which arises from the possibility that, when restricted to a sample, the reader's conclusions may be different from the conclusions that would be reached if the test were applied in the same way to all items in the population.

SECTION VI: FOCUSED CLAIM AUDITS

The engagement fieldwork for the focused claims audit was conducted remotely with the TPA. The remote fieldwork commenced Monday, June 20, 2022 and was concluded on Friday, June 24, 2022.

Scope

The focused claim audits covered the health benefits administered by the TPA on behalf of the Plan pursuant to its respective ASA Contract for high dollar claims, end stage renal disease claims, claim payments for duplicate or overlapping services, annual out-of-pocket maximums, and eligibility that were processed during the period from January 1, 2020 through December 31, 2020.

Objective

The engagement objective, as designed by a representative of the Plan Sponsor, with our assistance, was to assess the operational procedures and controls in place at the TPA related to the administration of:

1. Credit Balance and Denied Claims;
2. Annual Patient Liability Accumulation;
3. Claims that Involve Coordination of Benefits with Medicare or Other Insurance;
4. Coordination of Benefits – Potential Failure to Coordinate;
5. Out-of-Network Claims;
6. Claim Payments for Duplicate/Overlapping Services;
7. Claims for Non-Covered Services and/or Plan Limitations; and
8. Claims with Paid Amounts Greater Than Billed.

Procedures

The focused claim audits were not suitable for stratified statistical sampling. Therefore, we performed non-statistical, judgmental sampling techniques to test these claims. The credit balance and denied claims; annual patient liability accumulation; claims that involved coordination of benefits with Medicare or other insurance; coordination of benefits – potential failure to coordinate; out-of-network claims; claim payments for duplicate/overlapping services; claims for non-covered services and/or plan limitations; and claims with paid amounts greater than billed were subjected to the general engagement procedures listed below as well as the relative specific engagement procedures subsequently listed below.

General Engagement Procedures

Claims tested in the focused claim audits underwent a rigorous review by us in order to verify the following:

1. The claimant was eligible on the date of service;
2. Critical claim data fields were populated appropriately by the TPA;
3. The record of necessary documents was obtained by the TPA;
4. The allowable amount was properly determined by the TPA;
5. Patient liability was properly determined by the TPA;
6. The claim was mathematically accurate; and
7. The payment was issued to the correct party.

The following procedures were performed:

1. Verified the eligibility of the claimant on the date of service matches the eligibility information maintained by the Third Party Administrator;
2. Verified the coding of the procedure and diagnosis code on the provider's submitted bill matches the information on the claim processed by the TPA for payment;
3. Confirmed that the requisite referral(s), precertification(s), and/or authorization(s) for services are noted in the claims system, or that the applicable reduction of benefits and payment were applied;
4. For the sampled claims subjected to a contract review and/or processed based on COMAR regulations, verified the negotiated fee arrangement for in-network providers and other applicable fee arrangements applied to the claim match the contract or were calculated properly based on COMAR regulations);
5. Verified the mathematical accuracy of the claim payment;
6. Examined the claims history to ensure the claim was not duplicated or involved overlapping services for the same member, by the same provider, on the same date of service; and
7. Verified the payment was issued to the correct party based on the information contained in the claims system or support provided by the Third Party Administrator.

Specific Engagement Procedures

Claims tested in the focused claim audits underwent a specific review by us in order to verify the following:

1. Denied Claims

    a. We selected a non-statistical, judgmental claim sample of denied services by type of error in order to indicate the error types occurring most frequently and the dollar amounts associated with each error type;

2. Annual Patient Liability Accumulation.

    a. For each patient selected in the statistical claims sample, we examined the patient liability accumulation to determine if deductible(s) and out-of-pocket maximums were exceeded.

3. Claims that Involve Coordination of Benefits with Medicare or Other Insurance

    a. We selected a non-statistical, judgmental claim sample of claim payments involving coordination of benefits with either Medicare or other insurance.

4. Coordination of Benefits - Potential Failure to Coordinate

    a. We selected a non-statistical, judgmental claim sample of claim payments that appear to have failed to coordinate with Medicare or another insurance.

5. Out-of-Network Claims

    a. We selected a non-statistical, judgmental claim sample of claim payments issued for services rendered by an out-of-network provider.

6. Claim Payments for Duplicate/Overlapping Services

    a. We selected a non-statistical, judgmental claim sample of claim payments that appear to be duplicate payments for services rendered.

7. Claims for Non-Covered Services and/or Plan Limitations

a. We selected a non-statistical, judgmental claim sample of claim payments for services generally excluded or limited by the Plan.

8. Claims with Paid Amounts Greater Than Billed

a. We selected a non-statistical, judgmental claim sample of claim payments that exceeded the billed amount.

The following procedures were performed:

1. Denied Claims

a. Inspected the provider bill, claim information in the TPA's system, and the TPA's support for the reason for the payment/denial to determine if the denial was appropriate; and
b. Matched the overpayment amount, if applicable, in the TPA's claim system to the TPA's overpayment report.

2. Claims that Involve Coordination of Benefits with Medicare or Other Insurance

a. Verified the methodology of COB calculation used to determine the payment agrees with the requirements of the SPD or superseding Plan documents;
b. Examined the EOB of the other insurance carrier and verify the information on the EOB matches the information contained in the claims system; and
c. Verified the mathematical accuracy of the claim payment.

3. Coordination of Benefits - Potential Failure to Coordinate

a. Inspected the COB information within the TPA's system to determine if the Plan was secondary to Medicare or another insurance carrier;
b. Estimated the potential impact to the Plan due to failure to coordinate with the primary carrier;
c. When applicable (e.g., the primary insurance carrier denied payment), we examined the EOB of the other insurance carrier and verify the information on the EOB matches the information contained in the claims system; and
d. Verified the mathematical accuracy of the claim payment.

4. Out-of-Network Claims

a. Verified that the requisite notification, preauthorization, and/or precertification for services were noted in the claims system, or that any applicable reduction of benefits and payment were applied;
b. Reviewed the TPA support indicating the claim was properly submitted for re-pricing and/or determination of the reasonable and customary rate;
c. Verified the proper benefit level was applied to the services delivered to the member; and
d. Verified the mathematical accuracy of the claim payment.

5. Claim Payments for Duplicate/Overlapping Services

a. Inspected the provider bill, claim information in the TPA's system, claims history, and the TPA's support for the reason for the claim payment;
b. Verified the coding of the procedure and diagnosis code on the provider's submitted bill matches the information on the claim processed by the TPA for payment; and
c. Verified the mathematical accuracy of the claim payment.

6. Claims for Non-Covered Services and/or Plan Limitations

    a. Examined information contained in the eligibility and claims system related to the patient and/or provider to determine if the benefit determination was proper; and
    b. Examined each claim to verify that the methodology used to calculate the Plan's payment agrees to the language in the summary plan description.

7. Claims with Paid Amounts Greater Than Billed

    a. Verified the coding of the procedure and diagnosis code on the provider's submitted bill matches the information on the claim processed by the TPA for payment;
    b. Verified the negotiated fee arrangement for in-network providers and other applicable fee arrangements applied to the claim match the rate schedule contained in the claims system of the Third Party Administrator, or usual, customary, and reasonable (UCR) rates were properly applied, if applicable;
    c. Verified third-party liability provisions were properly applied;
    d. Verified plan benefits, limitations and exclusions were properly applied;
    e. Verified patient liability (i.e., deductibles, co-payments, and coinsurance) we properly applied; and
    f. Verified the mathematical accuracy of the claim payment.

Denied Claims

We selected a non-statistical, judgmental claim sample consisting of 20 individual claim samples of denied services by type of error in order to indicate the error types occurring most frequently and the dollar amounts associated with each error type. For each claim selected, we verified the accuracy of the claim processing, as well as performed the following procedures: (a) inspected the provider bill, claim information in the TPA's system, and the TPA's support for the reason for the payment/denial to determine if the denial was appropriate; and (b) matched the overpayment amount, if applicable, in the TPA's claim system to the TPA's overpayment report.

Our testing identified the following findings:

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
5	($273.65)	Agreed	Incorrectly Denied Claim in Error
11	($1,124.80)	Agreed	Incorrectly Denied Claim in Error

Procedural Findings

There were **no** procedural errors identified.

Annual Patient Liability Accumulation

We selected a non-statistical, judgmental sample consisting of 15 members that had claims involving annual patient liability accumulation. For each member selected, we examined the patient liability accumulation to determine if deductible(s) and out-of-pocket maximums were exceeded.

Our testing identified the following findings:

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
1	($580.43)	Agreed	Exceeded the Deductible
2	($3,571.25)	Agreed	Exceeded the Out-of-Pocket Maximum
4	($3,542.44)	Agreed	Out-of-Pocket Incorrectly Accumulated as In-Network Rather than Out-of-Network
5	($3,906.65)	Agreed	Incorrectly Applied Out-of-Network Benefits Instead of In-Network Benefits
6	($2,800.00)	Agreed	Exceeded the Out-of-Pocket Maximum
8	($2,070.80)	Agreed	Exceeded the Out-of-Pocket Maximum
9	($3,276.60)	Agreed	Exceeded the Out-of-Pocket Maximum
11	($4,566.66)	Agreed	Exceeded the Out-of-Pocket Maximum
12	($6,824.49)	Agreed	Exceeded the Out-of-Pocket Maximum
13	($806.66)	Agreed	Exceeded the Deductible
14	($120.91)	Agreed	Exceeded the Out-of-Pocket Maximum
15	($44,202.10)	Agreed	Exceeded the Out-of-Pocket Maximum

Procedural Findings

There were **no** procedural errors identified.

Claims that Involve Coordination of Benefits with Medicare or Other Insurance

We selected a non-statistical, judgmental claim sample consisting of 20 individual claim samples of claim payments involving coordination of benefits with either Medicare or other insurance. For each claim selected, we verified the accuracy of the claim processing, as well as performed the following procedures: (a) verified the methodology of COB calculation used to determine the payment agrees with the requirements of the SPD or superseding Plan documents; (b) examined the EOB of the other insurance carrier and verify the information on the EOB matches the information contained in the claims system; and (c) verified the mathematical accuracy of the claim payment.

Our testing identified the following findings:

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
1	$285.00	Agreed	Incorrect Coordination of Benefits Calculation (Failure to Use Medicare's Allowed Amount)
2	$399.60	Agreed	Incorrect Coordination of Benefits Calculation (Failure to Use Medicare's Allowed Amount
3	$25.00	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)
10	$384.88	Agreed	Failed to Apply Coinsurance
11	$1,347.95	Agreed to Error of $1,187.95	Incorrect Coordination of Benefits Calculation (TPA's Calculation Does Not Include the $200 Inpatient Co-Payment Applicable to the PPO 1250 Plan – The Difference is Not Exactly $200 Due to Additional Coinsurance Being Applied by the TPA)
13	$1,625.00	Agreed	Incorrect Coordination of Benefits Calculation
14	$296.75	Agreed	Incorrect Coordination of Benefits Calculation – Paid Above Patient's Legal Obligation
20	$3,713.40	Agreed	Incorrect Coordination of Benefits Calculation – Paid Above Patient's Legal Obligation

Procedural Findings

There were **no** procedural errors identified.

Coordination of Benefits – Potential Failure to Coordinate

We selected a non-statistical, judgmental claim sample consisting of 20 individual claim samples of claim payments that appear to have failed to coordinate with Medicare or another insurance. For each claim selected, we verified the accuracy of the claim processing, as well as performed the following procedures: (a) inspected the COB information within the TPA's system to determine if the Plan was secondary to Medicare or another insurance carrier; (b) estimated the potential impact to the Plan due to failure to coordinate with the primary carrier; (c) When applicable (e.g., the primary insurance carrier denied payment), we examined the EOB of the other insurance carrier and verify the information on the EOB matches the information contained in the claims system; and (d) verified the mathematical accuracy of the claim payment.

Our testing identified the following findings:

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
3	$102.14	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)
5	$2.29	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
8	$206.00	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)
9	$62.51	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)
10	$1,389.78	Agreed	Failed to Apply Deductible
12	$1,661.82	Agreed	Failed to Apply Deductible
16	$1,396.60	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)
17	$1,047.28	Agreed	Incorrect Coordination of Benefits Calculation
19	$2,130.33	Agreed	Incorrect Coordination of Benefits Calculation

Procedural Findings

Sample Claim Number	TPA Response	Description
8	Disagreed	Accumulated the Incorrect Out-of-Pocket Amount

Out-of-Network Claims

We selected a non-statistical, judgmental claim sample consisting of 20 individual claim samples of claim payments issued for services rendered by an out-of-network provider. For each claim selected, we verified the accuracy of the claim processing, as well as performed the following procedures: (a) verified that the requisite notification, preauthorization, and/or precertification for services were noted in the claims system, or that any applicable reduction of benefits and payment were applied; (b) reviewed the TPA support indicating the claim was properly submitted for re-pricing and/or determination of the reasonable and customary rate; (c) verified the proper benefit level was applied to the services delivered to the member; and (d) verified the mathematical accuracy of the claim payment.

Our testing identified the following findings:

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
6	$1,239.07	Agreed	Failed to Submit Out-of-Network Claim for Repricing (Multiplan)
9	$660.99	Agreed	Incorrectly Applied In-Network Benefits to Out-of-Network Claim
9	$218.19	Agreed	Duplicate Payment

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
12	($1,031.23)	Agreed	Incorrect Coinsurance Amount Applied
13	$4,241.14	Agreed	Incorrectly Applied In-Network Benefits to Out-of-Network Claim and Failed to Utilize Correct Out-of-Network Pricing
15 – 1	Unable to Determine	Agreed	Failed to Submit Out-of-Network Claim for Repricing (Multiplan)
15 – 2	$731.49	Agreed	Failure to Apply Coinsurance
17	$15,921.07	Disagreed	Incorrect Allowed Amount (TPA Agreed to a Procedural Error Indicating It Did Not Know The Pricing from the Host Plan at the Time of Processing)
18	$11,829.54	Agreed	Incorrect Allowed Amount – Failed to Apply In-Network Provider Contract
19	$20,172.59	Agreed	Incorrectly Applied Patient Liability to a Medicaid Reclamation Claim, and Applied an incorrect Medicaid Reimbursement
20	$4,273.72	Disagreed	Failed to Apply Patient Liability

The error identified on this claim is considered out-of-sample.

Procedural Findings

There were **no** procedural errors identified.

Claim Payments for Duplicate/Overlapping Services

We selected a non-statistical, judgmental claim sample consisting of 20 individual claim samples of claim payments that appear to be duplicate payments for services rendered. For each claim selected, we verified the accuracy of the claim processing, as well as performed the following procedures: (a) inspected the provider bill, claim information in the TPA's system, claims history, and the TPA's support for the reason for the claim payment; (b) verified the coding of the procedure and diagnosis code on the provider's submitted bill matches the information on the claim processed by the TPA for payment; and (c) verified the mathematical accuracy of the claim payment.

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
1	$22.73	Agreed	Duplicate Payment
4	$31.34	Disagreed	Duplicate Payment
6	$36.38	Agreed	Duplicate Payment

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
7	$43.83	Agreed	Duplicate Payment
9	$71.27	Disagreed	Duplicate Payment
10	$71.50	Agreed	Duplicate Payment
13	$26.00	Agreed	Duplicate Payment
15	$132.07	Agreed	Duplicate Payment
17	$10.00	Agreed	Duplicate Payment
18	$651.06	Agreed	Duplicate Payment

Procedural Findings

There were **no** procedural errors identified.

Claims for Non-Covered Services and/or Plan Limitations

We selected a non-statistical, judgmental claim sample consisting of 20 individual claim samples of claim payments for services generally excluded or limited by the Plan. For each claim selected, we verified the accuracy of the claim processing, as well as performed the following procedures: (a) examined information contained in the eligibility and claims system related to the patient and/or provider to determine if the benefit determination was proper; and (b) examined each claim to verify that the methodology used to calculate the Plan's payment agrees to the language in the summary plan description.

Our testing identified the following findings:

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
3	$22.00	Agreed	Incorrectly Paid for Excluded Services
4	$60.69	Disagreed	Incorrectly Paid for Excluded Services
5	$69.25	Disagreed	Incorrectly Paid for Excluded Services
10	$119.23	Disagreed	Incorrectly Paid for Excluded Services
11	$53.12	Agreed	Incorrectly Paid for Excluded Services

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
13	$220.34	Agreed	Incorrectly Paid for Excluded Services
16	$1,108.47	Disagreed	Incorrectly Paid for Excluded Services
17	$2,430.01	Disagreed	Incorrectly Paid for Excluded Services

Procedural Findings

There were **no** procedural errors identified.

Claims with Paid Amounts Greater Than Billed

We selected a non-statistical, judgmental claim sample consisting of 20 individual claim samples of claim payments that exceeded the billed amount. For each claim selected, we verified the accuracy of the claim processing, as well as performed the following procedures: (a) verified the coding of the procedure and diagnosis code on the provider's submitted bill matches the information on the claim processed by the TPA for payment; (b) verified the negotiated fee arrangement for in-network providers and other applicable fee arrangements applied to the claim match the rate schedule contained in the claims system of the Third Party Administrator, or usual, customary, and reasonable (UCR) rates were properly applied, if applicable; (c) verified third-party liability provisions were properly applied; (d) verified plan benefits, limitations and exclusions were properly applied; (e) verified patient liability (i.e., deductibles, co-payments, and coinsurance) we properly applied; and (f) verified the mathematical accuracy of the claim payment.

Our testing identified the following findings:

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description
17	$203.33	Agreed	Failure to Apply Coinsurance

Procedural Findings

There were **no** procedural errors identified.

Conclusion

We have determined, based on the limited testwork performed, that the TPA's administration of claims that involve annual patient liability accumulation; claims that involved coordination of benefits with Medicare or other insurance; coordination of benefits – potential failure to coordinate; out-of-network claims; duplicate claims; and claims for non-covered services and/or plan limitations does not meet the expectations of healthcare industry best practices. We also determined that the TPA's claims system is unable to flag all claim payments issued for previously paid services. These findings will be combined with the results of the other three (3) phases of the engagement to form an overall conclusion about the quality of the TPA's administration of the Plan.

Disclaimer

As a result of the non-statistical sampling techniques that were used to test each of the focused claim audits, the findings cannot be extrapolated over the population as the samples may not be representative of the population.

SECTION VII: ELECTRONIC CLAIMS REVIEW

The electronic claims review was conducted using our proprietary software and a sample of these findings were validated while conducting our remote fieldwork with the TPA. The remote fieldwork commenced Monday, June 20, 2022 and was concluded on Friday, June 24, 2022.

Scope

The electronic claims review covered the health benefits administered by the TPA on behalf of the Plan pursuant to its respective ASA Contract for all claims processed during the period from January 1, 2020 through December 31, 2020.

Scope Limitation

The results of the engagement are limited by the accuracy and completeness of the eligibility data provided to us, as well as the accuracy and completeness of the electronic healthcare claims data provided to us and the restrictions placed upon us by the TPA, which limits our access to certain claim and processor information in the claims systems in testing such data. One such limitation was the omission of a field in the data set to indicate the benefit level applied to a claim. Another example is the omission of override codes. These limitations prevented us from electronically reviewing non-network services paid at network benefits and the use of override codes.

Objective

The electronic claims review was designed by a representative of the Plan Sponsor, with our assistance, to evaluate the detailed paid claims file provided by the TPA for the engagement period to identify the following:

1. Evaluate the financial impact of the operational findings, as applicable;
2. Evaluate the financial impact of systemic and other measurable statistical and focused claim audits' findings, as applicable; and
3. Evaluate certain other Plan benefit determinations made by the TPA.

Procedures

We performed an electronic review of all claims processed by the TPA on behalf of the Plan to evaluate the following:

1. Duplicate payments;
2. Coordinated claims, such as Medicare, subrogation, and other insurance;
3. Unassigned benefits over $500;
4. Claims where the amount paid is greater than total charges;
5. Analyze use of override codes (if these codes are provided in the claims data provided);
6. Preferred provider claims without discounts;
7. Payments issued for certain Plan limitations;
8. Payments issued for certain Plan exclusions; and
9. Payments issued for certain unbundled laboratory services.

Summary of Findings and Observations

The results of our test work are as follows:

Findings

Description	Number of Claims	Potential Net Plan Overpayments
Potential Duplicate Payments (Professional)	153	$9,323.47
Lab Bundling	305	$10,901.23
Potential Duplicate Payments (Facility)	52	$26,548.62
Failure to Deny Payment for Certain Plan Benefit Exclusions and Limitations	2,062	$265,558.15
Totals	2,572	$312,331.47

Claim Populations

Description	Number of Claims	Total Billed	Total Paid	Total COB (If Applicable)
COB Claims	1,681	$13,294,475.01	$257,031.31	$1,314,294.32
Unassigned Benefits Over $500	51	$2,858,548.09	$24,962.50	$273,778.82
Net Paid Greater Than Net Billed	19	$9,099.15	$12,525.28	$0.00

Conclusion

The electronic claims review highlights the potential for significant claim payment errors within the claim populations. These potential errors and observations will be combined with the results of the other three (3) phases of the engagement to form an overall conclusion about the quality of the TPA's administration of the Plan.

Disclaimer

The potential claim payment errors identified above rely heavily on the accuracy and completeness of the claims data sets provided to us for testing. Although the testing we performed is intended to address the engagement objectives, it is important to note that, given the inherent limitations of the claim data sets utilized for this phase of the engagement coupled with the complexity of the benefit administration process, these tests are not designed to identify all potential errors that may be contained within the error categories specified above.

SECTION VIII: APPENDIX – TPA RESPONSE

Anthem Blue Cross and Blue Shield
Customer Audit Services
85 Crystal Run Road
Middletown, NY 10940
Mailpoint: NY0V04-019

1/6/2023

Via email only

Adam Meier
Senior Manager, TMDG
500 East Pratt Street, Suite 525, Baltimore MD 21202
ACMeier@tmdgllc.com
(443) 743-1293

Subject: Medical Plan Administration Performance Evaluation of Anthem, Inc., MCHCP – Response to Claims Audit Report

Dear Mr. Meier

It has been a pleasure working with you throughout this process. We appreciate the opportunity to respond to the draft report and the time you took to summarize your findings.

Anthem has reviewed TMDG's report prepared for the MCHCP claims audit. The fieldwork review consisted of 371 claims processed by Anthem during the audit period of January 1, 2020, through December 31, 2020. This audit was conducted remotely during the week of June 20, 2022. Anthem's response to the findings, observations, and recommendations are in italics below.

Observation No. 1 – Auto-Adjudication Rate

Observation: In its response to our questionnaire, the TPA reported an auto adjudication rate for the administration of the Plan during the engagement period of approximately 84%, which is within industry norms. We noted this is below the TPA's book of business auto adjudication rate of 88%.

Anthem's Response: The auto adjudication rate for 2020 was 85.57%, 2021 91.7% and 2022 current is 90.66%, which is within the industry norms and within the book of business norms. Please note the correct adjudication rate for 2020 is 85.57%, and the rate of 84.5% as indicated in the questionnaire was reported in error.

Finding No. 1 – Incorrect Member Liability Accumulation

Finding: During the course of the engagement, we identified 10 members whose deductible and/or out-of-pocket maximums were exceeded in amounts ranging from approximately $120 to more than $44,200.

Additionally, during our electronic claims review, we identified 1,069 instances in which it appears the TPA exceeded the deductible and/or out-of-pocket maximum. The results of our review are as follows:

Description	Number of Members	Potential Net Plan Underpayments
HSA Plan Family Accumulator	15	($2,971.24)
HSA Plan Individual Accumulator	3	($619.68)
PPO 750 Plan Family Accumulator	206	($49,821.11)
PPO 750 Plan Individual Accumulator	406	($134,164.14)
PPO 1250 Plan Family Accumulator	91	($77,971.63)
PPO 1250 Plan Individual Accumulator	348	($200,829.06)

Recommendation: We recommend that a representative of the Plan Sponsor meet with the TPA to discuss the reasons for these errors and the corrective action that will be put into place to correct this matter moving forward.

Anthem's Response: Of the 10 members TMDG identified during the remote audit as deductible and/or out-of-pocket maximums exceeded, Anthem agreed to 6 in-sample errors and 4 out-of-sample errors. The 6 in-sample errors in which the member's deductible and/or out-of-pocket maximums were exceeded resulted in a total underpayment amount of $57,938.04.

The underpayment errors identified for in-samples 6, 8, 9 and 11, and out-of-sample 12 were due to manual processing. The processor erroneously suppressed member cost share dollars from applying towards the out-of-pocket maximum, thus causing an overapplication in member liability. The underpayments for in-samples 14 and 15 were a result of the processor incorrectly applying member cost share when the OOP maximum had already been met at the time of processing. Refresher training was provided to the processors for each sample error. All in-sample claims have been adjusted to correct the underpayment.

The out-of-sample errors for samples 1 and 13 resulted when deductible dollars were not tracked towards the deductible maximum. Due to the age of the claims, Anthem was unable to identify the root cause for why these amounts did not apply to the member's deductible accumulators. Anthem has since corrected each member's deductible accumulators to include the missing dollar amounts.

The out-of-sample error for sample 2 resulted when the member moved from coverage under one plan to another. Accumulated out-of-pocket amounts already met under the previous plan should have been credited to the member's out-of-pocket accumulators under the new plan, however this did not occur and caused the member's out-of-pocket accumulation to become over applied. Anthem has corrected this member's file under the new plan.

Anthem does not agree to the findings of the electronic claims review. The 1,074 instances noted by TMDG were not part of the audit sample but were identified by an automated test. The claims were not reviewed by TMDG during the remote audit and were not reviewed by Anthem.

Finding No. 2 – Duplicate and Overlapping Payments

Finding: During our engagement, we sampled and tested 20 claims we flagged as potential duplicate payments within the paid claims data provided for the engagement. Of the 20 claims sampled, we verified that 10 were actual duplicate payments. We investigated the root cause of the sampled errors and was unable to determine any of the errors related to a systemic error condition. For the majority of the instances, the error was caused by a manual override of a system edit.

During our electronic claims review, we identified 205 instances in which it appears the TPA paid for duplicate/overlapping services. The results of our review are as follows:

Description	Number of Claims	Potential Net Plan Overpayments
Potential Duplicate Professional Claims	153	$9,323.47
Potential Duplicate Facility Claims	52	$26,548.62

Recommendation: We recommend that a representative of the Plan Sponsor request that the TPA review the duplicate claim payment errors we identified during the focused claims audit to determine the root cause and nature of that error. Based on the nature of the problem, we would expect the TPA to develop a corrective action plan to address the matter. Additionally, we would recommend the Plan Sponsor expand the engagement test work to include additional testing in order to maximize the recovery opportunity for these claims.

Anthem's Response: During the remote audit review, Anthem agreed to 8 duplicate errors for samples 1, 6, 7, 10, 13, 15, 17 and 18, for a total overpayment of $993.54. In each case the duplicate overpayment was due to manual processing. Refresher training was provided to the processors for each in-sample error.

Anthem continues to disagree to the errors assessed by TMDG for samples 4 and 9 due the potential duplicate claims having different charges and different rendering providers.

Anthem does not agree to the findings of the electronic claims review. The 205 instances noted by TMDG were not part of the audit sample but were identified by an automated test. The claims were not reviewed by TMDG during the remote audit and were not reviewed by Anthem.

Finding No. 3 – Administration of Co-Payments

Finding: During the course of the engagement, we identified several issues related to the administration of co-payments as described below:

1. Failed to waive emergency room co-payment for emergent medical conditions;
2. Incorrectly applied a co-payment instead of deductible and/or coinsurance; and
3. Failed to apply a co-payment.

Recommendation: We recommend that a representative of the Plan Sponsor request that the TPA review the co-payment errors we identified to determine the root cause and nature of that error. Based on the significance of this issue, we would expect the TPA to develop a corrective action plan to address the matter.

Anthem's Response: Anthem agrees to two errors related to the misapplication of co-payment. The underpayment for Statistical sample 57 resulted when the $250 copay was applied to a truly emergent emergency room visit in error. Per the Plan's benefit documentation, the $250 copay should be waived for emergency medical conditions. This benefit coding issue was identified and corrected by Anthem in 2021 and a report was generated at the time of the system fix to adjust all impacted claims. Sample 57 was not captured for adjustment on the original report, so Anthem generated a new report which identified 4 additional claims (including sample 57) that required adjustment.

Anthem also agrees to the $185.87 overpayment error for Statistical sample 176. The processor failed to apply the $200 copay for an inpatient stay. Refresher training was provided to the processor.

Anthem originally disagreed to the errors assessed by TMDG for Statistical samples 84 and 105. In both cases the claim billed surgery in an office setting. The Plan's benefit documentation states surgery in office will pay at 100% after a copay. However, after further review and email confirmation received from the Plan, surgery in office should apply deductible and coinsurance. Anthem's client management will generate an impact report for 2020, 2021 and 2022 and provide total impact to the Plan in order to determine next steps.

Finding No. 4 – Payment of Claims for Non-Covered Services and/or Plan Limitations

Finding: We utilized rule based algorithms to identify and electronically evaluate claim payments related to certain general plan exclusions and limitation to assess the risk of financial loss to the plan due to claim payment errors related to this area. The testing utilized the claim data set that was provided for this engagement, which contains limited information about each claim. Our evaluation identified numerous instances of claim payment anomalies which if investigated further by the TPA might reveal a claim payment error. The claim payment anomalies totaled approximately $266,000 with the most significant dollars occurring in the following four (4) categories: educational or psychological testing; non-covered medical supplies; eye glasses or lenses; and maxillofacial surgery. We performed additional testing on 20 claims and determined eight (8) were in error. However, the TPA agreed to only three (3) errors. It is more than reasonably possible that upon further review of the remaining claims in question, the TPA would determine the vast majority of these claims were properly paid by the Plan.

Recommendation: We recommend the Plan Sponsor consider providing a sample of the largest claims (e.g., those over $5,000) to the TPA for further investigation. We would also recommend that the TPA continue to evaluate the four (4) categories where the majority of the financial risk to the plan exists in future engagements.

Anthem's Response: Anthem agrees three in-sample claims allowed payment for excluded services in error, totaling $295.46 in overpayments. Samples 3, 11 and 13 were manually processed. Refresher training was provided to the processors. These claims will not be adjusted as they are under the $30 threshold for recovery or beyond the timeframe for recovery.

Anthem disagrees to the errors assessed by TMDG for samples 2, 4, 5, 8, 10, 16 and 17. Samples 2 4, 5, 8 and 10 were office visits billed with qualifying diagnoses. The office visit is considered a payable service and is not considered treatment of a non-payable condition.

Samples 16 and 17 were medical supplies billed by a durable medical equipment provider and were utilized as part of the member's home health care. Medical supplies are covered under the Plan's benefits.

Anthem does not agree to the findings of the electronic claims review. The claim payment anomalies noted by TMDG as a result of the electronic review were not part of the audit sample. The claims were not reviewed by TMDG during the remote audit and were not reviewed by Anthem.

Finding No. 5 – Claim Payment Timeliness

Finding: During the statistical claims audit portion of this engagement, we calculated the claim payment timeliness found within the statistical samples. Of the 216 statistical sample claims selected for review, 210 claims were considered non-investigated medical claims and included in the claim payment timeliness calculation. Of those 210 claims, 67 were processed more than 14 calendar days after the received date. This provides a timeliness processed percentage (i.e., claims processed within 14 calendar days of the received date) of 68.10%. With respect to the 14 calendar day processing requirement outlined in the performance guarantees, the TPA is below the performance guarantee standard and it appears 100% of the $100,000 penalty is due.

During our remote testing, the TPA provided the following statement regarding the claim payment timeliness issues identified: “A backlog of claims had occurred in 2020 due to COVID-19. The client is aware of the delays and missed opportunity in meeting claim timeliness performance guarantees during 2020."

We requested the claims inventory backlog as part of our questionnaire. The TPA responded that the backlog details are not included as part of its audit reporting.

On December 15, 2022, the Plan Sponsor provided the letter it issued to Anthem on May 20, 2021, which stated the following:

> After carefully reviewing your request for relief in the payout of the missed 2020 performance guarantees penalties due to Covid-19 operational impacts for claim timelines, written inquiries and average speed to answer. MCHCP can agree to suspend the collection of these three penalties. If Anthem meets or exceeds performance standards for these guarantees in 2021, then the 2020 suspended guarantee penalties will not be collected. Should Anthem not meet the three guarantee standards in 2021, MCHCP will agree to collect both the 2020 and 2021 penalties at that time. If this is acceptable by Anthem, we will notate the performance guarantees to reflect this agreement.

Recommendation: We recommend that a representative of the Plan Sponsor meet with the TPA to discuss the reasons for untimely processing of claims and the corrective action that will be put into place to correct this matter moving forward. We also recommend the Plan Sponsor assess whether Anthem met its performance guarantee metrics for 2021 and if the penalty for missing the 2020 metrics is due.

Anthem’s Response: For 2020 the turnaround time was impacted by COVID and resource transition to working virtually. In 2021 our overall turnaround time improved and the result was 95.66% which exceeded the goal, and we are on track to meet the goal for 2022.

Finding No. 6 – Coordination of Benefits (COB) with Medicare or Other Insurance

Finding: During the course of the engagement we noted the following types of COB errors:

1. Incorrect COB Calculation
2. Incorrect COB Calculation – Paid Above Patient’s Legal Obligation

It is important to note some of the findings related to the TPA failing to limit the Plan's allowed amount to the lesser allowed by either the primary carrier or the TPA.

Because of certain limitations placed upon the claims data set provided to us for this engagement by the TPA, we were unable to electronically evaluate the potential financial impact of these issues.

Recommendation: We recommend that a representative of the Plan Sponsor request that the TPA review the errors we identified to determine the root cause and nature of these errors. Based on the nature of the problem, we would expect the TPA to develop a corrective action plan to address the matter.

Anthem's Response: Anthem agrees to the overpayment errors for COB samples 2, 10, 11, 13, 14 and 20. Total overpayment for these samples is $7,607.58. Each error was due to manual mishandling of the claim and failure to apply correct calculation for coordination of benefits. Refresher training was provided to the processors. Samples 2, 10, 11 and 20 have been adjusted to correct payment. Samples 13 and 14 will not be adjusted as it is now beyond the timeframe for recovery.

Anthem agrees to the $285.00 overpayment error for COB sample 1. Anthem made a payment on this claim, however after coordination with Medicare, Anthem's payment should have been zero. After further investigation Anthem has determined the root cause to also be manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.

Anthem also agrees to the errors cited for Potential Failure to Coordinate samples 10, 12, 17 and 19, for a total overpayment of $6,229.21. For samples 10 and 12 the processor failed to apply the correct amount towards the member's deductible. For samples 17 and 19 the processor failed to apply member cost share, allowing the claims to be paid at 100% in error. Refresher training was provided to the processors.

Anthem disagrees to the overpayment errors for COB sample 3 and Potential Failure to Coordinate samples 3, 5, 8, 9 and 16. TMDG cited these as errors due to "Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)." Anthem's standard processing for Hard Non-Dup COB calculation is to use Anthem's allowed to determine what Anthem would have paid had we been the primary carrier, and then subtract the primary carrier's payment. Anthem will never pay more than the other insurance carrier patient responsibility amount. Anthem's standard Hard Non-Dup process was set up for the Plan at the time of the group's implementation. Anthem's client management team is available to discuss the COB options available to the Plan.

It is important to note that TMDG cited a procedural error for Potential Failure to Coordinate sample 8, indicating 'no response.' Anthem responded to TMDG's inquiry via email on 8/3/22 and then again on 9/8/22 providing the claim rate details and the patient liability amount that was calculated using Anthem's allowed amount. Anthem disagrees to this procedural error.

Observation No. 2 – Overpayment Recovery Reporting

Observation: For the engagement period, the TPA reported $4,917,764.32 in overpayments that were credited to the Plan. These overpayments related to corrected claim/updated billing from provider, incorrect billing, duplicate payment, provider audit, member policy/contract not in effect at the time of service, incorrect member policy number/group number, member cancelled, benefit loaded/configured incorrectly in system, services not covered per member benefits, not medically necessary, durable medical equipment, incorrect reimbursement rate, system pricing loaded/configured incorrectly, corrected pricing received from Host Plan, manual processing deductible error, copay/deductible/coinsurance, payee refunded payment, paid to wrong

provider/payee, COB on the claim was either not applied or applied incorrectly, COB – commercial carrier primary, COB – Medical primary, COB – commercial carrier adjusted original payment, 60 days ITS home adjustment, and front end data entry error.

Anthem's Response: Anthem's client management team is available to discuss the standard reporting with MCHCP upon request. This report reflects overpayments identified through our internal auditing processes and includes overpayments caused by provider billing errors, pricing updates, COB validations, subrogation and internal processing errors.

Statistical Claims Audit

Detailed Financial Findings

Sample Claim Number	Amount in Error Overpayment/ (Underpayment)	TPA Response	Description	Anthem's Remote Fieldwork Response
18	($202.64)	Disagreed	Incorrectly Applied Patient Liability to Preventive Services	Anthem disagrees to the out-of-sample underpayment of $202.64. Claim billed a primary diagnosis which is not considered preventive. Out-of-sample claim processed as medical (non-preventive) based on the primary diagnosis billed. This procedure requires a preventive primary diagnosis to be billed to be considered preventive.
30	($530.00)	Agreed	Incorrectly Applied Patient Liability to Preventive Services	Anthem agrees out-of-sample claim applied deductible in error, resulting in an underpayment of $530. An issue was identified in which deductible was applying to routine colonoscopy in error and correction was made to the system. Claim was adjusted on 7/7/22 and deductible no longer applied. Sample claim now pays as routine at 100%.
47	$56.12	Agreed	Failed to Apply Coinsurance	Anthem agrees to the overpayment error of $56.12. The error is due to manual processing. Claim was adjusted on 7/5/22 to apply coinsurance.
57	($250.00)	Agreed	Failed to Waive Emergency Room Co-Payment for Emergency Medical Condition	Sample claim applied the $250 copay in error. An issue was identified in which copay applied to true emergent ER visit in error and correction was made to the system in 202. This claim will not be adjusted as it is now beyond the timeframe for adjustment.
84	$1,296.67	Disagreed *Anthem now agrees with the overpayment error	Failed to Apply Deductible and Coinsurance - Incorrectly Applied a Co-Payment	Anthem originally disagreed to the $1,296.67 overpayment. Per the Benefit Plan Design, surgery in office pays at 100% after copay. *However, after further review and email confirmation received from the Plan, surgery in office should apply deductible and coinsurance.

				This claim will not be adjusted as it is now beyond the timeframe for adjustment.
99	$1,190.93	Agreed	Failed to Apply Coinsurance	Anthem agrees to the overpayment error of $1,190.93. Error was due to manual processing. Claim was adjusted on 7/15/22 to apply coinsurance.
101	$1,435.45	Disagreed	Failure to Apply Patient Liability – Incorrectly Applied COVID Benefits	Anthem disagrees. The primary diagnosis was added to the mandate for Covid 19 on 10/14/20. This was retroactive with an effective date of 6/1/20. The adjustment of the claim on 1/12/21 processed under the Covid 19 guidelines to waive cost shares based on the diagnosis.
105	$1,486.22	Disagreed *Anthem now agrees with the overpayment error	Failed to Apply Deductible and Coinsurance - Incorrectly Applied a Co-Payment	Anthem originally disagreed with $1,486.22 overpayment. Per Anthem's Benefit Plan Design, surgery in an office setting applies a copay, it does not stipulate copay only on office visit. *However, after further review and email confirmation received from the Plan, surgery in office should apply deductible and coinsurance. This claim will not be adjusted as it is now beyond the timeframe for adjustment.
109	$3,154.07	Agreed	Incorrect Patient Liability Amounts Applied	Anthem agrees to the overpayment error of $3,154.07. Error was due to manual processing. Claim was adjusted on 7/19/22 to apply correct member cost share.
111	$153.01	Agreed	Failed to Apply Coinsurance	Anthem agrees to the overpayment error of $153.01. Error was due to manual processing. Claim was adjusted on 7/22/22 to apply correct member cost share.
113	$994.58	Agreed	Failed to Apply Coinsurance	Anthem to the overpayment error of $994.58. Error was due to manual processing. Claim was adjusted on 7/19/22 to apply correct member cost share.
121	$2,011.38	Disagreed *Anthem now agrees with the overpayment error	Failed to Apply Coinsurance	Anthem originally disagreed with $2,011.38 overpayment. Per Anthem's Benefit Plan Design, surgery in an office setting applies a copay *However, after further review and email confirmation received from the Plan, surgery in office should apply deductible and coinsurance. This claim will not be adjusted as it is now beyond the timeframe for adjustment.
134	$4,262.13	Agreed	Incorrect Patient Liability Amounts Applied	Anthem agrees to an overpayment amount of $4,262.13. Error was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.

137	$2,824.41	Agreed	Failed to Apply Coinsurance	Anthem agrees to the $2,824.41 overpayment error. The sample claim should have applied coinsurance to meet the OOP maximum of $8,150. Error was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
142	($20,460.00)	Agreed	Incorrect Allowed Amount	Anthem agrees to the $20,460.00 underpayment on the first adjustment of the claim, performed on 6/22/21. Correct rate was applied upon the second adjustment on 5/12/22.
143	$269.43	Agreed	Failed to Apply Coinsurance	Anthem agrees to this error. The examiner manually calculated the OOP incorrectly. The OOP has since been met so no adjustments are necessary. Anthem agrees to a $269.43 overpayment.
146	$0.02	Agreed	Incorrect Deductible Amount Applied	Agree to an overpayment of $0.02, claims processor manually applied $1136.88 to deductible when adjusting claim rather than $1136.90 to meet $1250 individual In-network deductible.
169	$32,895.43	Disagreed	Failed to Deny Claims for a Member with No Coverage Under the Plan	Anthem disagrees to the $32,895.43 in-sample overpayment error. The sample claim was correctly allowed for payment at the time of processing on 7/1/2020. Member termination information was not received by Anthem from the group until 8/17/20, at which point the member was retro terminated back to 2/1/2020. Recoveries for termed members are restricted to claims incurred within a maximum of 60 days prior to the notification/process date. 60 days prior to 8/17/20 is 6/19/20. The date of service of the sample claim is 6/14/20, therefore would not be eligible for recovery.
169	$19,966.06	Disagreed	Failed to Deny Claims for a Member with No Coverage Under the Plan	Anthem disagrees to the $19,966.06 out-of-sample overpayment error. The out-of-sample claims were correctly allowed for payment at the time of processing. Member termination information was not received by Anthem from the group until 8/17/20, at which point the member was retro terminated back to 2/1/2020. Recoveries for termed members are restricted to claims incurred within a maximum of 60 days prior to the notification/process date. 60 days prior to 8/17/20 is 6/19/20. Only dates of service within this timeframe would be eligible for recovery.
176	$185.87	Agreed	Failed to Apply a Co-Payment	At the time the adjustment on 10/15/20, member had 2031.16 accumulated in OOP. Processor only applied 32.97 in coinsurance. Anthem will agree to $185.87 overpayment error. Error was due to manual processing.

				This claim will not be adjusted as it is now beyond the timeframe for recovery.
201	$1,138.21	Agreed	Failed to Apply a Co-Payment	Claim was manually adjusted and should have applied cost share on this claim, processor error. The out-of-pocket would have been met on this claim if processed correctly. At the time of processing, $1138.21 was left to meet the In-network individual OOP maximum of $2250. OOP maximum. OOP max has since been met. Agree to $1138.21 overpayment at the time of processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.

The error identified on this claim is considered out-of-sample. Therefore, the amount will not be included in the total financial errors when calculating the statistical claims audit results.

Focused Claim Audits

Denied Claims

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description	Anthem's Remote Fieldwork Response
5	($273.65)	Agreed	Incorrectly Denied Claim in Error	Sample claim is a Medicaid reclamation claim. Anthem will reimburse the total paid amount back to Medicaid. In this case, Medicaid made a payment of $273.65. Processor denied the sample claim in error. Anthem will agree to an underpayment of $273.65. This claim will not be adjusted as it is now beyond the timeframe for adjustment.
11	($1,124.80)	Agreed	Incorrectly Denied Claim in Error	This member does not show as Medicare primary, therefore should not have been denied as disallowed by Medicare. Allowance for this service should be $1,406. Member's deductible was met prior to this claim processing, so coinsurance applied would have been $281.20. Anthem will agree to an underpayment of $1,124.80. Anthem determined this error was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for adjustment.

Annual Patient Liability Accumulation

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description	Anthem's Remote Fieldwork Response
1	($580.43)	Agreed	Exceeded the Deductible	Anthem agrees the out-of-sample claim did not accumulate deductible dollars towards the family deductible accumulator. Anthem agrees to an out-of-sample error of $580.43. This member's file has now been corrected.
2	($3,571.25)	Agreed	Exceeded the Out-of-Pocket Maximum	The out-of-sample error for sample 2 resulted when the member moved from coverage under one plan to another. Accumulated out-of-pocket amounts already met under the previous plan should have been credited to the member's out-of-pocket accumulators under the new plan, however this did not occur and caused the member's out-of-pocket accumulation to become over applied. Anthem has corrected this member's file under the new plan
4	($3,542.44)	Agreed	Out-of-Pocket Incorrectly Accumulated as In-Network Rather than Out-of-Network	Anthem agrees out-of-sample claim accumulated INN rather than OON. Due to the age of the claim, Anthem was unable to identify the root cause.
5	($3,906.65)	Agreed	Incorrectly Applied Out-of-Network Benefits Instead of In-Network Benefits	Anthem agrees sample claim is underpaid. Member cost share should have applied towards the INN OOP. At the time of original processing on 7/24/20, member had met $3,712.13 in INN OOP. Therefore, Anthem will agree to an underpayment of $3906.65. Sample claim was adjusted on 6/29/22 to apply only $16.00 in coinsurance to meet the member's OOP max of $3750. Anthem determined this error was due to manual processing.
6	($2,800.00)	Agreed	Exceeded the Out-of-Pocket Maximum	Anthem agrees to the $2,800.00 underpayment error. At the time the sample claim was adjusted on 4/1/20, the processor suppressed member cost share from applying towards the OOP accumulator in error. Underpayment was caused due to manual processing. Claim was adjusted on 9/30/22 to pay at 100% as OOP has been satisfied.
8	($2,070.80)	Agreed	Exceeded the Out-of-Pocket Maximum	Anthem agrees to the $2,070.80 underpayment error. At the time the sample claim was adjusted on 11/18/20, the processor suppressed member cost share

				from applying towards the OOP accumulator in error. Underpayment was caused due to manual processing. Claim was adjusted on 6/24/22 to correct payment.
9	($3,276.60)	Agreed	Exceeded the Out-of-Pocket Maximum	Anthem agrees to the $3,276.60 underpayment error. At the time the sample claim was adjusted on 12/5/20, the processor suppressed member cost share from applying towards the OOP accumulator in error. Underpayment was caused due to manual processing. Claim was adjusted on 7/12/22 to pay at 100%.
11	($4,566.66)	Agreed	Exceeded the Out-of-Pocket Maximum	Anthem agrees to the $4,566.66 underpayment error. At the time the sample claim was adjusted on 11/05/20, the processor suppressed member cost share from applying towards the OOP accumulator in error. Underpayment was caused due to manual processing. Claim was adjusted on 6/24/22 to correct payment.
12	($6,824.49)	Agreed	Exceeded the Out-of-Pocket Maximum	Anthem will agree to an out-of-sample $6,824.49 underpayment error. At the time the out-of-sample claim was originally processed on 10/9/20, the processor suppressed member cost share from applying towards the OOP accumulator in error. Underpayment was caused due to manual processing. The out-of-sample claim was adjusted on 7/25/22 to pay at 100% since OOP has now been met.
13	($806.66)	Agreed	Exceeded the Deductible	Anthem agrees two out-of-sample claims did not accumulate deductible dollars towards the family deductible accumulator. This member's file has now been corrected.
14	($120.91)	Agreed	Exceeded the Out-of-Pocket Maximum	Anthem agrees the sample claim was underpaid at the time of original processing on 6/4/2020. At that time, the INN individual OOP maximum of $8,150 had been met, as well as the INN Family OOP maximum of $9,900. The sample claim applied coinsurance in error. Claim should have been paid at 100% since OOP was met. Claim is underpaid $1,021.88. Error due to manual processing. Sample claim was later adjusted on 6/18/22, after adjustments on other claims had occurred. When the sample claim was adjusted, a total of $1,922.85 was applied in member's cost share to meet the $8,150 OOP maximum correctly.
15	($44,202.10)	Agreed	Exceeded the Out-of-Pocket	Anthem agrees to the underpayment of $44,202.10. The claim should have paid at

			Maximum	100% since the member's OOP was met at the time of processing. This error was due to manual processing. Claim was adjusted on 8/2/22 to pay at 100% as OOP is satisfied.

Claims that Involve Coordination of Benefits with Medicare or Other Insurance

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description	Anthem's Remote Fieldwork Response
1	$285.00	Agreed	Incorrect Coordination of Benefits Calculation (Failure to Use Medicare's Allowed Amount)	Anthem agrees the sample claim is overpaid $285.00. Anthem made a payment on this claim, however after coordination with Medicare, Anthem's payment should have been zero. After further investigation Anthem has determined the root cause to be manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
2	$399.60	Agreed	Incorrect Coordination of Benefits Calculation (Failure to Use Medicare's Allowed Amount	Anthem agrees to an overpayment amount of $399.60. Error is due to manual processing. Claim was adjusted on 8/19/22 to correct payment.
3	$25.00	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)	Anthem's standard processing for Hard Non Dup COB calculation is to use Anthem's allowed to determine what Anthem would have paid had we been the primary carrier, and then subtract the primary carrier's payment. Anthem will never pay more than the other insurance carrier patient responsibility amount. Anthem's standard Hard Non Dup process was set up for MCHCP at the time of the group's implementation.
10	$384.88	Agreed	Failed to Apply Coinsurance	Anthem agrees MCHCP coinsurance was not applied to the sample claim. Error was due to manual processing. Claim was adjusted on 7/19/22 to correct payment.
11	$1,347.95	Agreed to Error of $1,187.95	Incorrect Coordination of Benefits Calculation (TPA's Calculation Does Not Include the $200 Inpatient Co-Payment Applicable to the PPO 1250 Plan – The Difference is Not Exactly $200	Anthem agrees to an overpayment amount of $1,187.95. Error was due to manual processing. This claim was not part of a delivery. The benefits for this plan do not have a $200 copay for Inpatient Facility, per Anthem's benefit plan design.

			Due to Additional Coinsurance Being Applied by the TPA)	Claim was adjusted on 6/24/22 to correct payment.
13	$1,625.00	Agreed	Incorrect Coordination of Benefits Calculation	Anthem agrees to a $1,625.00 overpayment error for this claim. Error was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
14	$296.75	Agreed	Incorrect Coordination of Benefits Calculation – Paid Above Patient's Legal Obligation	Anthem agrees to the overpayment error of $296.75. Error was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
20	$3,713.40	Agreed	Incorrect Coordination of Benefits Calculation – Paid Above Patient's Legal Obligation	Anthem agrees to the overpayment error of $3,713.40. Anthem would not pay more than the Other Carrier's patient responsibility amount. Error was due to manual processing. The sample claim was adjusted on 7/12/22 to correct the overpayment.

Coordination of Benefits – Potential Failure to Coordinate

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description	Anthem's Remote Fieldwork Response
3	$102.14	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)	Anthem's standard processing for Hard Non Dup COB calculation is to use Anthem's allowed to determine what Anthem would have paid had we been the primary carrier, and then subtract the primary carrier's payment. Anthem will never pay more than the other insurance carrier patient responsibility amount. Anthem's standard Hard Non Dup process was set up for MCHCP at the time of the group's implementation.
5	$2.29	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)	Anthem's standard processing for Hard Non Dup COB calculation is to use Anthem's allowed to determine what Anthem would have paid had we been the primary carrier, and then subtract the primary carrier's payment. Anthem will never pay more than the other insurance carrier patient responsibility amount. Anthem's standard Hard Non Dup process was set up for MCHCP at the time of the group's implementation.
8	$206.00	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's	Anthem's standard processing for Hard Non Dup COB calculation is to use Anthem's allowed to determine what Anthem would have paid had we been the primary carrier,

			Allowed or Primary Carrier's Allowed)	and then subtract the primary carrier's payment. Anthem will never pay more than the other insurance carrier patient responsibility amount. Anthem's standard Hard Non Dup process was set up for MCHCP at the time of the group's implementation.
9	$62.51	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)	Anthem's standard processing for Hard Non Dup COB calculation is to use Anthem's allowed to determine what Anthem would have paid had we been the primary carrier, and then subtract the primary carrier's payment. Anthem will never pay more than the other insurance carrier patient responsibility amount. Anthem's standard Hard Non Dup process was set up for MCHCP at the time of the group's implementation.
10	$1,389.78	Agreed	Failed to Apply Deductible	Anthem agrees to the overpayment error of $1,389.78. The full allowance should have been applied to the member's deductible at the time of processing. Error was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
12	$1,661.82	Agreed	Failed to Apply Deductible	Anthem agrees to the overpayment error of $1,661.82 for Potential COB Sample 12. Error was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
16	$1,396.60	Disagreed	Incorrect Coordination of Benefits Calculation (Failure to Use the Lesser of Anthem's Allowed or Primary Carrier's Allowed)	Anthem's standard processing for Hard Non Dup COB calculation is to use Anthem's allowed to determine what Anthem would have paid had we been the primary carrier, and then subtract the primary carrier's payment. Anthem will never pay more than the other insurance carrier patient responsibility amount. Anthem's standard Hard Non Dup process was set up for MCHCP at the time of the group's implementation.
17	$1,047.28	Agreed	Incorrect Coordination of Benefits Calculation	Anthem agrees deductible and coinsurance should have applied to this claim. Error was due to manual processing. Claim was adjusted on 7/20/22 to correct payment.
19	$2,130.33	Agreed	Incorrect Coordination of Benefits Calculation	Anthem agrees to the overpayment error of $2,130.33. Error was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.

Procedural Findings

Sample Claim Number	TPA Response	Description	Anthem's Remote Fieldwork Response
8	Disagreed	Accumulated the Incorrect Out-of-Pocket Amount	Anthem responded to TMDG's inquiry via email on 8/3/22 and then again on 9/8/22 providing the claim rate details and the patient liability amount that was calculated using Anthem's allowed amount. Anthem disagrees to this procedural error.

Out-of-Network Claims

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description	Anthem's Remote Fieldwork Response
6	$1,239.07	Agreed	Failed to Submit Out-of-Network Claim for Repricing (Multiplan)	Anthem agrees to the overpayment of $1,239.07. Sample claim should have been routed to MPI (NCN) for Data iSight pricing. Error due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
9	$660.99	Agreed	Incorrectly Applied In-Network Benefits to Out-of-Network Claim	Anthem will agree to an overpayment error of $660.99 on the sample. Error due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
9	$218.19	Agreed	Duplicate Payment	Anthem will agree to an out-of-sample overpayment error of $218.19. Manual keying error. This claim will not be adjusted as it is now beyond the timeframe for recovery.
12	($1,031.23)	Agreed	Incorrect Coinsurance Amount Applied	Anthem agrees to the $1,031.23 underpayment error. Sample claim incorrectly applied $4,693.60 in coinsurance. Error was due to manual processing. The claim was adjusted on 7/25/22 to apply the correct coinsurance amount of 3,662.37.
13	$4,241.14	Agreed	Incorrectly Applied In-Network Benefits to Out-of-Network Claim and Failed to Utilize Correct Out-of-Network Pricing	The examiner failed to route the claim for negotiation and allowed the claim to price at billed charges in error. Anthem agrees the claim allowed billed charges in error. Additionally, the examiner applied INN benefit amounts to this OON provider claim in error. Anthem will agree to an $4,241.14 overpayment error.

				This claim will not be adjusted as it is now beyond the timeframe for recovery.
15 – 1	Unable to Determine	Agreed	Failed to Submit Out-of-Network Claim for Repricing (Multiplan)	Anthem will agree to a procedural error for failure to route claim for negation.
15 – 2	$731.49	Agreed	Failure to Apply Coinsurance	Anthem agrees to the $731.49 overpayment. Error due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
17	$15,921.07	Disagreed	Incorrect Allowed Amount (TPA Agreed to a Procedural Error Indicating It Did Not Know The Pricing from the Host Plan at the Time of Processing)	The examiner failed to have claim resubmitted through the Host plan, therefore the claim was paid incorrectly. Had the claim been resubmitted through ITS, the Host plan would have passed the contractual allowance for this provider's claim. Anthem is unable to determine what the pricing would have been had this been submitted through ITS. Due to this, Anthem will agree to a procedural error but is unable to agree to a financial error without knowing the Local Host Plan allowance. This claim will not be adjusted as it is now beyond the timeframe for recovery.
18	$11,829.54	Agreed	Incorrect Allowed Amount – Failed to Apply In-Network Provider Contract	Claim allowance was determined using an incorrect provider network. Provider is participating. Correct pricing should have been 60% of charges. Anthem will agree to an overpayment of $11,829.54. Due to the age of the claim Anthem is unable to determine root cause. This claim will not be adjusted as it is now beyond the timeframe for recovery.
19	$20,172.59	Agreed	Incorrectly Applied Patient Liability to a Medicaid Reclamation Claim, and Applied an incorrect Medicaid Reimbursement	Sample claim is a Medicaid Reclamation claim. Anthem will reimburse the total paid amount back to Medicaid. In this case, Medicaid made a payment of $47,808.95. Processor applied member cost share in error, and also overpaid Medicaid. Claim should have reimbursed Medicaid only $47,808.95. Anthem will agree to an overpayment of $20,172.59. Error due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
20	$4,273.72	Disagreed	Failed to Apply Patient Liability	Anthem disagrees to the overpayment error of $4,273.72. Claim processed as INN and at the time of processing, member had met their INN OOP max of $2250.00. The provider information passed on the SCCF shows this provider as PPO. Please also note the patient was admitted through the ER.

The error identified on this claim is considered out-of-sample.

Claim Payments for Duplicate/Overlapping Services

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description	Anthem's Remote Fieldwork Response
1	$22.73	Agreed	Duplicate Payment	Agree - manual processing resulted in duplicate payment of $22.73. This is under the $30 threshold for recovery
4	$31.34	Disagreed	Duplicate Payment	Disagree - Charges are different and patient account numbers are different
6	$36.38	Agreed	Duplicate Payment	Agree - a manual adjustment made to a history claim caused the duplication. This claim will not be adjusted as it is now beyond the timeframe for recovery.
7	$43.83	Agreed	Duplicate Payment	Agree - manual processing resulted in duplicate payment of $43.83. One claim is Medicaid reclamation claim, second claim should have denied as duplicate. This claim will not be adjusted as it is now beyond the timeframe for recovery.
9	$71.27	Disagreed	Duplicate Payment	Disagree - two different rendering providers
10	$71.50	Agreed	Duplicate Payment	Agree - manual processing error. This claim will not be adjusted as it is now beyond the timeframe for recovery.
13	$26.00	Agreed	Duplicate Payment	Agree that duplicate payment was made for date of service 5/8 only; amount of $26.00. Under the $30 recovery threshold
15	$132.07	Agreed	Duplicate Payment	Agree - manual processing resulted in duplicate payment of $132.07. This claim will not be adjusted as it is now beyond the timeframe for recovery.
17	$10.00	Agreed	Duplicate Payment	Agree that $10 duplicate payment was made for date of service 1/29. Under $30 recovery threshold
18	$651.06	Agreed	Duplicate Payment	Agree to duplicate payment due to manual processing error. This claim will not be adjusted as it is now beyond the timeframe for recovery.

Claims for Non-Covered Services and/or Plan Limitations

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description	Anthem's Remote Fieldwork Response
3	$22.00	Agreed	Incorrectly Paid for Excluded Services	Agree - Manual processing caused the overpayment of $22.00 This amount is under the $30 threshold for recovery
4	$60.69	Disagreed	Incorrectly Paid for Excluded Services	Anthem disagrees to the overpayment error of $60.69 and continues to maintain this service is covered. The service billed is an office visit, which is a covered service. The diagnosis alone would not be denied as not covered.
5	$69.25	Disagreed	Incorrectly Paid for Excluded Services	Anthem disagrees to the overpayment error of $69.25 and continues to maintain this service is covered. This office visit and surgery are covered benefits.
10	$119.23	Disagreed	Incorrectly Paid for Excluded Services	Anthem disagrees to the overpayment error of $119.23 and continues to maintain this service is covered. This office visit and surgery are covered benefits.
11	$53.12	Agreed	Incorrectly Paid for Excluded Services	Anthem agrees to the $53.12 overpayment. Overpayment was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.
13	$220.34	Agreed	Incorrectly Paid for Excluded Services	Agree - Manual processing caused the overpayment of $220.34. This claim will not be adjusted as it is now beyond the timeframe for recovery.
16	$1,108.47	Disagreed	Incorrectly Paid for Excluded Services	Anthem disagrees to the overpayment error and continues to maintain these services are covered.
17	$2,430.01	Disagreed	Incorrectly Paid for Excluded Services	Anthem disagrees to the overpayment error and continues to maintain these services are covered.

Claims with Paid Amounts Greater Than Billed

Financial Findings

Sample Claim Number	Amount In Error Overpayment / (Underpayment)	TPA Response	Description	Anthem's Remote Fieldwork Response
17	$203.33	Agreed	Failure to Apply Coinsurance	Anthem agrees to the error of $203.33. Error was due to manual processing. This claim will not be adjusted as it is now beyond the timeframe for recovery.

Thank you for allowing Anthem the opportunity to respond to this draft report. Anthem's representatives are available to discuss the results of this audit with TMDG and MCHCP upon request and we look forward to working with TMDG and MCHCP in the future.

Sincerely,

Sent via email

Gina Posner
External Audit Lead
Customer Audit Services

cc: Jami Rector, Anthem
Stephanie Vojicic, Anthem
Katie Parker, Anthem
Marijane Gadbury, Anthem