UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2024

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-16751

ELEVANCE HEALTH, INC.
(Exact name of registrant as specified in its charter)

Indiana	**35-2145715**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**

220 Virginia Avenue
Indianapolis, Indiana 46204
(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code: (833) 401-1577

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading symbol(s)	Name of each exchange on which registered
Common Stock, Par Value $0.01	ELV	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b) ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all directors and executive officers of the registrant are "affiliates") as of June 30, 2024, was approximately $116,687,067,115.

As of February 1, 2025, 227,351,871 shares of the registrant's common stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 14, 2025.

Elevance Health, Inc.

Annual Report on Form 10-K
For the Year Ended December 31, 2024

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References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Elevance Health" or the "Company" refer to Elevance Health, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the term "states" include the District of Columbia and Puerto Rico, unless the context otherwise requires.

FORWARD-LOOKING STATEMENTS

This document contains certain forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements reflect our views about future events and financial performance and are generally not historical facts. Words such as "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan" and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various risks and other disclosures discussed in our reports filed with the U.S. Securities and Exchange Commission from time to time, which attempt to advise interested parties of the factors that affect our business. Except to the extent required by law, we do not update or revise any forward-looking statements to reflect events or circumstances occurring after the date hereof. These risks and uncertainties include, but are not limited to: trends in healthcare costs and utilization rates; reduced enrollment; our ability to secure and implement sufficient premium rates; the impact of large scale medical emergencies, such as public health epidemics and pandemics, and other catastrophes; the impact of new or changes in existing federal, state and international laws or regulations, including laws and regulations impacting healthcare, insurance, pharmacy services and other diversified products and services, or their enforcement or application; the impact of cyber-attacks or other privacy or data security incidents or our failure to comply with any privacy, data or security laws or regulations, including any investigations, claims or litigation related thereto; failure to effectively maintain and modernize our information systems; failure of our information systems or technology, including artificial intelligence, to operate as intended; failure to effectively maintain the availability and integrity of our data; changes in economic and market conditions, as well as regulations that may negatively affect our liquidity and investment portfolios; competitive pressures and our ability to adapt to changes in the industry and develop and implement strategic growth opportunities; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon; our ability to maintain and achieve improvement in Centers for Medicare and Medicaid Services Star Ratings and other quality scores and funding risks with respect to revenue received from participation therein; a negative change in our healthcare product mix; costs and other liabilities associated with litigation, government investigations, audits or reviews; our ability to contract with providers on cost-effective and competitive terms; risks associated with providing healthcare, pharmacy and other diversified products and services, including medical malpractice or professional liability claims and non-compliance by any party with the pharmacy services agreement between us and CaremarkPCS Health, L.L.C.; the effects of any negative publicity related to the health benefits industry in general or us in particular; risks associated with mergers, acquisitions, joint ventures and strategic alliances; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; possible restrictions in the payment of dividends from our subsidiaries and increases in required minimum levels of capital; our ability to repurchase shares of our common stock and pay dividends on our common stock due to the adequacy of our cash flow and earnings and other considerations; the potential negative effect from our substantial amount of outstanding indebtedness and the risk that increased interest rates or market volatility could impact our access to or further increase the cost of financing; a downgrade in our financial strength ratings; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; intense competition to attract and retain employees; risks associated with our international operations; and various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations.

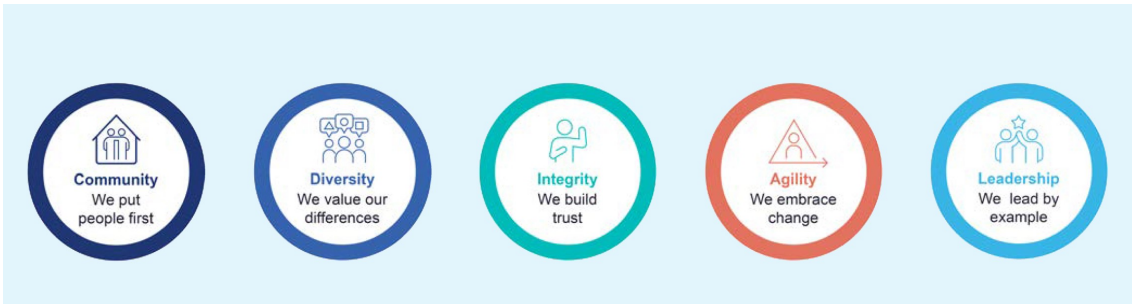
PART I

ITEM 1. BUSINESS.

General

Elevance Health and its direct and indirect subsidiaries, referred to throughout this document as "we," "us," "our," the "Company" or "Elevance Health," is a leading health company bringing together the concepts of elevate and advance, in order to exemplify and follow our purpose of improving the health of humanity. We serve people across their entire health journey to better address their full range of needs with an integrated whole-health approach. Through our broad view, we aim to meaningfully improve the health of the people and communities we serve. We strive to deliver on our mission by maximizing the power of partnerships, innovating to fuel growth and health equity, and maintaining a high-performance culture. Our strategy is to be a lifetime trusted health partner through the following four core competencies:

With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:



We are one of the largest health insurers in the United States in terms of medical membership, serving approximately 45.7 million medical members through our affiliated health plans as of December 31, 2024. We offer a broad spectrum of

network-based managed care risk-based plans to Individual, Employer Group, Medicaid and Medicare markets. In addition, we provide a broad array of managed care services to fee-based customers, including claims processing, stop loss insurance, provider network access, medical management, care management, wellness programs, actuarial services and other administrative services. We provide services to the federal government in connection with our Federal Health Products & Services business, which administers the Federal Employee Program® ("FEP®"). We provide an array of specialty services both to customers of our subsidiary health plans and to unaffiliated health plans, including pharmacy services, stop loss insurance, dental, vision and supplemental health insurance benefits, as well as integrated health services.

We are an independent licensee of the Blue Cross and Blue Shield Association ("BCBSA"), an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield ("BCBS") licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross and Anthem Blue Cross and Blue Shield. We also conduct business through arrangements with other BCBS licensees, as well as other strategic partners. In addition, we serve members in numerous states as Wellpoint, Carelon, MMM and/or Simply Healthcare. We are licensed to conduct insurance operations in all 50 states, the District of Columbia and Puerto Rico through our subsidiaries. Through various subsidiaries, we also offer pharmacy services through our CarelonRx business, and other healthcare related services as Carelon Insights and Carelon Health.

We have organized our brand portfolio into the following core go-to-market brands:

- Anthem Blue Cross/Anthem Blue Cross and Blue Shield — represents our Anthem-branded and affiliated Blue Cross and/or Blue Shield licensed plans;
- Wellpoint — unites select non-BCBSA licensed Medicare, Medicaid and commercial plans under the Wellpoint name; and
- Carelon — this brand brings together our healthcare related services and capabilities, including our CarelonRx and Carelon Services businesses, under a single brand name.

We report our results of operations in the following four reportable segments: Health Benefits, CarelonRx, Carelon Services and Corporate & Other (our businesses that do not individually meet the quantitative thresholds for an operating segment, as well as corporate expenses not allocated to our other reportable segments).

For additional discussion, see "Reportable Segments" below in this "Business" section and Note 1, "Organization," and Note 20, "Segment Information," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We believe healthcare is local and that we have the strong local presence required to understand and meet local customer needs with regard to any product customers are enrolled in with us. Further, we believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and healthcare professionals. Ultimately, we believe that practical and sustainable improvements in healthcare must focus on improving healthcare quality while managing costs for total affordability. We have implemented initiatives driving payment innovation and partnered with providers to lower cost and improve the quality of healthcare for our members, and we continue to develop new and innovative ways to effectively manage risk and engage our members. Further, we continue to expand our financial arrangements with providers to implement payment models that advance value-based care. We believe focusing on quality of care rather than volume of care is the foundation for improving patient outcomes. Our value-based payment models support patient-centered care by improving collaboration between providers and health partners and delivering to our members the right care, at the right time, in the right place. In addition, we are focused on achieving efficiencies from our national scale while optimizing service performance for our customers. Finally, we expect to continue to rationalize our portfolio of businesses and products and align our investments to optimize our core businesses, invest in high-growth opportunities, and accelerate value creation through expanded capabilities and services.

Impact on Our Results of Operations

Our results of operations depend in large part on our ability to accurately predict and effectively manage healthcare costs through effective contracting with providers of care to our members, product pricing, medical management and health and wellness programs, including service coordination and case management for addressing complex and specialized healthcare needs, innovative product design and our ability to maintain or achieve improvement in our Centers for Medicare and Medicaid Services ("CMS") Star Ratings. CMS Star Ratings affect Medicare Advantage plan reimbursements as well as our eligibility to earn quality-based bonus payments for those plans. See "Regulation" below in this "Business" section for additional information on our CMS Star Ratings. For additional information on our networks and provider relations, product pricing and healthcare cost management programs, see "Pricing and Underwriting of Our Products," "Networks and Provider Relations," "Medical Management Programs," "Care Management and Wellness Products and Programs" and "Healthcare Quality Initiatives" below in this "Business" section.

Advances in medical technology, including new specialty drugs, and new indications for existing prescription drugs, changes in regulations, the aging population and other demographic characteristics continue to contribute to rising healthcare costs. Our managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs by using the full range of our innovative medical management services, health outcomes-based initiatives and health quality-based financial incentives. We believe our market position and high business retention rates will enable us to realize the long-term benefits of investing in preventive and early detection programs. Our ability to provide cost-effective health benefits products and services is enhanced through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. In addition, our ability to manage operating expenses continues to be a driver of our overall profitability.

Our future results of operations will be impacted by certain external forces and resulting changes in our business model and strategy. Changes to our business environment will continue as elected officials at the national and state levels enact modifications to existing laws and regulations, including changes to available subsidies, taxes and fees. For additional discussion, see "Regulation" below in this "Business" section and Part I, Item 1A "Risk Factors" included in this Annual Report on Form 10-K.

Our results of operations are also impacted by levels and mix of membership, which has changed, and will continue to change, as a result of the quality and pricing of our health benefits products and services, Medicaid redeterminations, an aging population, healthcare utilization patterns, previously uninsured members entering the healthcare system, provider and member fraud, economic conditions, changes in unemployment, the continued and future impact of large-scale emergencies, acquisitions, entry into new markets and expansions in or exits from existing markets. These membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes, changes in how our members access healthcare services or our exit from a specific market. See Part I, Item 1A "Risk Factors" and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

We continue to enhance interactions with customers, providers, brokers, agents, employees and other stakeholders through digital technology and improvements to internal operations. Our approach includes not only the sales and distribution of health benefits products through digital technology, but also implementing advanced capabilities that improve services benefiting customers, agents, brokers and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of healthcare through increased communications between patients and their physicians.

Through our participation in various federal government programs, we generated approximately 31%, 29% and 28% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2024, 2023 and 2022, respectively. The majority of these revenues are contained in our Health Benefits segment as described below. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S. and Puerto Rico.

Reportable Segments

We report our results of operations in the following four reportable segments: Health Benefits, CarelonRx, Carelon Services and Corporate & Other (our businesses that do not individually meet the quantitative thresholds for an operating segment, as well as corporate expenses not allocated to our other reportable segments).

Our Health Benefits segment offers a comprehensive suite of health plans and services to our Individual, Employer Group risk-based, Employer Group fee-based, BlueCard®, Medicare, Medicaid and FEP® members. The Health Benefits segment offers health products on a full-risk basis; provides a broad array of administrative managed care services to our fee-based customers; and provides a variety of specialty and other insurance products and services such as stop loss, dental, vision and supplemental health insurance benefits.

Our CarelonRx segment includes our pharmacy services business. CarelonRx markets and offers pharmacy services to our affiliated health plan customers, as well as to external customers outside of the health plans we own. CarelonRx offers a comprehensive portfolio of pharmacy services, which includes all core pharmacy services, such as home delivery and specialty pharmacies, claims adjudication, formulary management, pharmacy networks, rebate administration, a prescription drug database and member services. In addition, CarelonRx includes ambulatory infusion centers, added to our portfolio in March 2024 through our acquisition of Paragon Healthcare, Inc. and its subsidiaries.

Our Carelon Services segment integrates physical, behavioral, pharmacy, and social services with the aim of delivering whole health affordably by offering a broad array of healthcare related services and capabilities to internal and external customers through our Carelon Health and Carelon Insights businesses. Our Carelon businesses promote affordability by managing complex areas of the healthcare system, leveraging data and insights to improve how our members receive safe, appropriate, high-quality care and providers are reimbursed accurately and timely. Our approach to cost management relies on capabilities including provider enablement, value-based networks, member engagement, and utilization management. Our care delivery services primarily target serving chronic and complex populations by providing personalized care in the home and virtually. As a part of Carelon Health, we completed our acquisition of RSV QOZB LTSS, Inc. and certain affiliated entities (d/b/a CareBridge) at the end of 2024, which provides virtual care to complex Medicaid and Medicare patients and supports plans in managing home and community-based services.

Our Corporate & Other segment includes our businesses that do not individually meet the quantitative threshold for an operating segment, as well as corporate expenses not allocated to our other reportable segments.

For additional information, see Note 20, “Segment Information,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Membership

Our medical membership includes the following customer types: Individual, Employer Group risk-based, Employer Group fee-based, BlueCard®, Medicare, Medicaid and FEP®. In addition, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, as well as the unique needs of educational and public entities, labor groups, the FEP®, national employers and state-run programs servicing low-income, high-risk and underserved markets. Overall, we seek to establish pricing and product designs to provide value for our customers while achieving an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers’ unique needs.

We market our Individual, Medicare and certain Employer Group products with a smaller employee base through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships. Products for commercial customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer who work with industry specialists from our in-house sales force. In the Individual markets, we offer on-exchange products through state- or federally-facilitated marketplaces (the “Public Exchange”) in compliance with the Patient

Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively, the "ACA") and off-exchange products. Federal subsidies are available for certain members, subject to eligibility, who purchase Public Exchange products.

We continue to participate in the Public Exchange in nearly all of our Anthem Blue Cross and Anthem Blue Cross and Blue Shield service areas. We anticipate growth in our Public Exchange membership as former Medicaid members, no longer eligible for Medicaid coverage, continue to seek alternative coverage options. Additionally, we are entering select service areas in Florida, Maryland, and Texas in 2025, using our Simply Healthcare and Wellpoint brands, and we are actively evaluating expansion opportunities in additional marketplaces beyond 2025. See "Regulation" below in this "Business" section for additional discussion about the Public Exchange marketplace.

Being a licensee of the BCBS association of companies, of which there were 33 independent primary licensees including us as of December 31, 2024, provides significant market value, especially when competing for very large multi-state employer groups. For example, each BCBS member company is able to utilize other BCBS licensees' substantial provider networks and discounts when any BCBS member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard®. BlueCard® host members are generally members who reside in or travel to a state in which an Elevance Health subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan serviced by a non-Elevance Health controlled BCBS licensee, which is the "home" plan. We perform certain administrative functions for BlueCard® host members, including claims pricing and administration, for which we receive service fees from the BlueCard® members' home plan. Other administrative functions, including maintenance of enrollment information and customer services, are performed by the home plan. See "BCBSA Licenses" below in this "Business" section for additional information on our BCBSA licenses. We refer to members in our service areas licensed by the BCBSA as our BCBS-branded, or Anthem BCBS, business. Non-BCBS-branded business refers to members in our non-BCBS-branded plans, which include Wellpoint, MMM and Simply Healthcare plans.

For additional information describing each of our customer types and changes in medical membership over the last three years, see "Management's Discussion and Analysis of Financial Condition and Results of Operations - *Membership*" included in Part II, Item 7 of this Annual Report on Form 10-K.

Product and Service Descriptions

Various forms of managed care products have been developed to contain the cost of healthcare by negotiating contracts with hospitals, physicians and other providers to deliver high-quality healthcare to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network physicians and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the healthcare system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, such as smoking cessation and weight management. Members are charged periodic, prepaid premiums and generally pay copayments, coinsurance and/or deductibles when they receive services.

Health Benefits

- *Commercial Risk-Based Products.* We offer employer groups a diversified mix of managed care risk-based products including: Preferred Provider Organization ("PPO"), Health Maintenance Organization ("HMO"), Consumer-Driven Health Plans ("CDHP"), Traditional Indemnity and Point-of-Service ("POS") plans. PPO plans generally provide members the freedom to choose any healthcare provider, but require the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. HMOs include comprehensive managed care benefits generally through a participating network of physicians, hospitals and other providers. CDHPs generally combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account, which may result in tax benefits to the employee and allow some or all of the dollars remaining in the personal care account at year-end to be rolled over to the next year for future healthcare needs. Traditional indemnity plans offer the member an option to select any healthcare provider for covered services, with coverage subject to deductibles and coinsurance and with member cost-sharing usually limited by out-of-pocket maximums. POS products

blend the characteristics of HMO, PPO and indemnity plans. In general, POS plans allow members to choose to seek care from a provider within the plan's network or outside the network, subject to, among other things, certain deductibles and coinsurance.

We also offer Individual risk-based products on and off the Public Exchange, covering essential health benefits (as defined in the ACA) along with many other requirements and cost-sharing features.

- *Commercial Fee-Based Products.* We provide a broad array of managed care services to fee-based groups, including claims processing, provider network access, medical management, care management and wellness programs, actuarial services and other administrative services. Fee-based health plans are also able to use our provider networks and to realize savings through our negotiated provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. We also charge a premium to underwrite stop loss insurance for employers that maintain fee-based plans but want to limit their retained risk.

  In addition, we perform certain administrative functions for BlueCard® host members, discussed under "Membership" above, including claims pricing and administration, for which we receive service fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

- *Specialty Products.* We offer an array of products and services to both risk-based and fee-based customers in conjunction with our health plans as well as to unaffiliated healthcare plans that are not Elevance Health subsidiaries.
  - *Stop Loss Insurance.* Our stop loss insurance arrangements are built around our clients' needs while assuming 100% of the risk. We offer specific and aggregate plans that will provide options to meet our clients' coverage terms, budget and risk tolerance; active claims management to help avoid errors and missing claims; as well as cost containment to assist our clients with claims and cost control.
  - *Dental.* Our dental plans include networks in certain states in which we operate and are offered on both a risk-based and fee-based basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans that offers in-network discounts across the country.
  - *Vision.* Our vision plans include networks within the states in which we operate and are offered on both a risk-based and fee-based basis.
  - *Supplemental Health.* We offer supplemental health products, including accident, critical illness and hospital indemnity, which provide coverage for specific conditions or circumstances.

- *Medicare Plans.* We offer a wide variety of plans, products and options to individuals age 65 and older such as Medicare Advantage, including Special Needs Plans ("SNPs"), dual-eligible programs through Medicare-Medicaid Plans ("MMPs"), Medicare Supplement plans and Medicare Part D Prescription Drug Plans ("Medicare Part D").

  Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage SNPs provide tailored benefits to special needs individuals who are institutionalized or have severe or disabling chronic conditions and to dual-eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Advantage SNPs are coordinated care plans specifically designed to provide targeted care, covering all the healthcare services considered medically necessary for members and often providing professional care coordination services, with personal guidance and programs that help members maintain their health. Medicare Advantage membership also includes Medicare Advantage members in our Group Retiree Solutions business who are retired members of commercial accounts or groups who are not affiliated with our commercial accounts that have selected a Medicare Advantage product through us. MMP is focused on serving members who are dually eligible for Medicaid and Medicare. Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by the traditional Medicare Fee-For-Service program. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries.

- *Medicaid Plans and Other State-Sponsored Programs.* Our Medicaid business includes our managed care alternatives through public-funded healthcare programs, including Medicaid; Medicaid expansion programs; Temporary Assistance for Needy Families ("TANF"); programs for seniors and people with disabilities ("SPD"); Children's Health Insurance

Programs (“CHIP”); and specialty programs such as those focused on long-term services and support (“LTSS”), HIV/AIDS, children living in foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities and/or developmental disabilities. The Medicaid program makes federal matching funds available to all states for the delivery of healthcare benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. Our Medicaid plans also cover certain dual-eligible customers, as previously described above, who also receive Medicare benefits. In 2024, we provided Medicaid and other state sponsored services, such as administrative services, in Arkansas, California, Colorado, District of Columbia, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia and Wisconsin.

- *Federal Employee Program®.* FEP® members consist of United States government employees and their dependents within our geographic markets.
- *Medicare Administrative Operations.* We serve as a fiscal intermediary, carrier and Medicare administrative contractor for the federal government by providing administrative services for the Medicare program, Parts A and B, which generally provides coverage for persons who are 65 or older and for persons who are under 65 and disabled or with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other healthcare facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies.

Carelon

Carelon integrates physical, behavioral, social and pharmacy services to deliver whole health affordably by creating value through the offering of market-competitive services powered by analytics.

CarelonRx

Our subsidiary CarelonRx markets and offers pharmacy services to our affiliated health plan customers throughout the country, as well as to customers outside of the health plans we own. Our comprehensive pharmacy services portfolio includes all core pharmacy services, such as home delivery and specialty pharmacies, claims adjudication, formulary management, pharmacy networks, rebate administration, a prescription drug database and member services, as well as infusion services and injectable therapies through owned ambulatory infusion centers.

CarelonRx delegates certain core pharmacy services to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation (“CVS”), pursuant to an agreement (the “CVS Agreement”) with the current contractual term extending through December 31, 2027. We can elect to have CVS continue to provide services to us for a three-year extension period on the same terms and conditions as in the current CVS Agreement in the event of a termination or non-renewal by either party.

Carelon Services

Carelon Services integrates physical, behavioral, pharmacy, and social services with the aim of delivering whole health affordably by offering a broad array of healthcare related services and capabilities to internal and external customers through our Carelon Health and Carelon Insights businesses. Carelon businesses promote affordability by managing complex areas of the healthcare system, leveraging data and insights to improve how our members receive safe, appropriate, high-quality care and providers are reimbursed accurately and timely. Our approach to cost management relies on capabilities including provider enablement, value-based networks, member engagement, and utilization management. Our care delivery services primarily target serving the chronic and complex populations by providing personalized care in the home and virtually.

- *Carelon Health:* Carelon Health, powered by clinical excellence, curates value-based whole health solutions for populations, one person at a time. Carelon Medical Benefits Management provides specialty care enablement and utilization management support for specialized clinical domains. Carelon Post Acute Solutions manages home health, post-acute institutional management, and durable medical equipment costs. Carelon Behavioral Health provides comprehensive behavioral health management services through clinical services and network

administration. Carelon Care Navigation provides comprehensive care management services. Our Carelon Advanced Primary Care business includes palliative care services and management of our partnership with Augusta Topco Holdings L.P. ("Mosaic Health"), a joint venture with Clayton, Dubilier & Rice ("CD&R"). At the end of 2024, we completed our acquisition of CareBridge, which provides virtual care to complex Medicaid and Medicare patients and supports plans in managing home and community-based services.

- *Carelon Insights:* Carelon Insights aims to improve the health of the healthcare system by simplifying workflows and providing real-time insights. Carelon Insights capabilities include payment integrity, subrogation, clinical data exchange through our HealthOS platform, research and data services, reporting and clinical analytics, and information technology services and global business process support.

Competition

The managed care industry is highly competitive, both nationally and in our local markets. Competition continues to be intense due to aggressive marketing, pricing, bid activity for government-sponsored programs, business consolidations, new strategic alliances, new competitors in the market, a proliferation of new products, technological advancements, the impact of legislative reform, increased quality awareness and price sensitivity among customers and changing market practices, such as increased usage of telehealth.

We believe that participants in the managed care industry compete for customers based on quality of service, price, access to provider networks, access to care management and wellness programs (including health information), innovation, effective use of digital technology, breadth and flexibility of products and benefits, expertise and reputation (including National Committee on Quality Assurance ("NCQA") accreditation status as well as CMS Star Ratings), brand recognition and financial stability. Our ability to attract and retain customers is substantially tied to our ability to distinguish ourselves from our competitors in these areas.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with greater brand recognition over competitive product offerings. Typically, we are the largest participant in each of our BCBS branded markets, and thus are closely watched by other health benefits companies.

Product pricing remains competitive, and we strive to price our health benefit products and design our Medicare and Medicaid bids consistent with anticipated underlying medical trends. We believe our pricing and bid strategy, based on predictive modeling, proprietary research and data-driven processes, has positioned us to benefit from the potential growth opportunities available through entry into new markets, expansions in existing markets and as a result of any future changes to the current regulatory scheme. We believe that our pricing and bid strategy, brand name and network quality will provide a strong foundation for membership growth opportunities in the future.

Our provider networks give us a highly competitive unit cost position and provide distinctive service levels which allow us to offer a broad range of affordable health benefit products to our customers. To build our provider networks, we compete with other health benefits plans for the best contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider customer volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan.

At the sales and distribution level, we compete for qualified agents and brokers to recommend and distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to secure new business and maintain existing accounts. We believe that the quality and price of our products, support services, reputation and prior relationships, along with a reasonable commission structure, are the factors agents and brokers consider in choosing whether to market our products. We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to those of our competitors in all of our markets.

In addition, the pharmacy industry is highly competitive, and CarelonRx is subject to competition from national, regional and local pharmacy service providers, insurers, health plans, large retail pharmacy chains, large retail stores, supermarkets, mail order pharmacies, web pharmacies and specialty pharmacies. Strong competition within the pharmacy industry has

generated greater demand for lower product and service pricing, increased revenue sharing and enhanced product and service offerings.

Pricing and Underwriting of Our Products

We price our products based on our assessment of current healthcare claim costs and emerging healthcare cost trends, combined with charges for administrative expenses, risk and profit. We continually review our product designs and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our strategies and profitability goals.

Our revenue on Medicare policies is based on annual bids submitted to CMS. We base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period. In applying our pricing to each employer group and customer, we aim to maintain consistent, competitive and disciplined underwriting standards. We employ our proprietary accumulated actuarial and financial data to determine underwriting and pricing parameters for both our risk-based and fee-based businesses.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. For our risk-based business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience or charged against future favorable experience. In addition, our ACA and government risk-based contracts may include minimum medical loss ratio, risk adjustment, or risk corridor arrangements, which also stabilize premiums based upon claims experience.

Our pharmacy services pricing through CarelonRx is presented to market via discounts off the average wholesale price for drugs dispensed through the retail, mail and specialty channels as well as through rebate projections. We utilize group-specific script data, formulary, network and clinical care program selection combined with administrative expense, risk and profit guidance to set market competitive pricing discounts and rebate projections. Pharmacy services pricing guidelines guide the underwriting process and undergo an annual external review process to ensure market competitiveness.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that render healthcare services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. While following industry standards, we are simultaneously seeking to lead transformation efforts within our healthcare system, moving from a fragmented model premised on episodic intervention to one based on proactive, coordinated care built around the whole health needs of the patient.

We establish "market-based" hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. In most instances, we deploy multi-year contracting strategies, including fixed case rates and fee schedules, to limit our exposure to medical cost inflation and to increase cost predictability. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad-based networks with smaller or more cost-conscious networks that are designed to be attractive to a more price-sensitive customer segment, such as Public Exchange customers.

Our reimbursement strategies are tailored to each market and reflect the degree of consolidation and integration of physician groups and hospitals. Under a fee-for-service reimbursement methodology for physicians, fee schedules are developed at the state level based on an assessment of several factors and conditions, including the CMS resource-based relative value system ("RBRVS"), medical practice cost inflation and physician supply of each specialty. We utilize CMS RBRVS fee schedules as a reference point for fee schedule development and analysis. The RBRVS structure was developed, maintained, and updated by CMS and is used by the Medicare program and other major health plans. In addition, we have implemented and continue to expand physician incentive contracting, which ties physician payment levels to performance on efficiency, clinical and patient experience measures.

While we generally do not delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement, we maintain capitation-based arrangements in certain markets where we determine that market dynamics result in it being a useful method to lower costs and reduce underwriting risk. Our provider engagement and contracting strategies have evolved to include value-based contracting arrangements that meet providers where they are in the movement from traditional fee-for-service to value-based care. These programs are designed to support commercial, Medicare and Medicaid programs and the unique characteristics of these populations. Our value-based contracting programs are designed to reward our contracted providers for improving the overall quality of care they deliver by adhering to evidence-based medicine. In addition, these value-based contracts also share with the providers total cost of care savings that are achieved by adhering to evidence-based medicine over time. For providers who contract in one of our value-based programs, we work with them to share gaps in care information and other important data to assist them in managing the care of their patients. Often providers will also grant us access to data to support the efficient administration of program components. This data can allow us to more efficiently capture information regarding the risk of our membership and the overall adherence to evidence-based medicine, as well as information to more efficiently perform utilization management administration.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a per-case amount, per admission, for inpatient covered services. Our "per-case" reimbursement methods utilize many of the same attributes contained in Medicare's Diagnosis Related Groups methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. A small percentage of hospitals, primarily rural, sole community hospitals, are reimbursed on a discount from approved charge basis for covered outpatient services. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or sole community hospitals, and the volume of care performed for our members. To improve predictability of expected costs, we frequently use a multi-year contracting approach with providers. In addition, the majority of our hospital contracts include a pay-for-performance component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Seasonality

Within our Health Benefits segment, although premium revenues for our commercial business are not seasonal, our benefit costs rise as members pay their contractual portion of claims responsibility, hitting their deductibles and out-of-pocket maximums. Seasonality in our Medicaid business can vary depending on the timing of the recognition of premium rates during the year, and we typically experience additional costs in our Medicare business in the fourth quarter to support the annual enrollment period.

Our Carelon Services segment engages in risk-based contracts with members across many health plans including Elevance Health plans. These risk-based contracts allow our Health Benefits segment to reduce medical expense variability by replacing seasonal claims costs with agreed-upon pricing. Seasonality in our Carelon Services segment aligns with the claims and revenue seasonality for services covered, which can vary by Carelon product and line of business. As the year progresses, members will generally reach their deductible and out-of-pocket maximum limit, and benefit expense in our Carelon Services businesses will typically increase to cover member costs.

Medical Management Programs

We have a broad array of medical management activities that facilitate improvements in the quality of care provided to our members and promote cost-effective medical care. These medical management activities and programs are administered and directed by physicians and nurses with the goal of ensuring that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate setting. The medical management programs available to our members may vary depending on the particular plan or product in which they participate.

Care coordination is one of the strategies we utilize and is based on nationally recognized criteria developed by third-party medical specialists to help coordinate inpatient as well as outpatient care and monitor appropriate utilization of such services. Our case management focuses on identifying membership that will require a high level of intervention and providing assistance to manage their healthcare needs. Precertification is utilized to assess appropriateness of certain medical services and sites of care prior to the services being rendered. Our medical policy committee determines our national policies

and guidelines for the application of medical technologies, procedures and services and reviews these policies and guidelines at least once a year or as new published clinical evidence becomes available. We are actively engaged with our hospital and physician networks to enable them to achieve better outcomes for our members. We also work with outside experts through a process of external review to provide our members scientifically and clinically evidence-based medical care. Our web-based tools allow our members to obtain or compare cost estimates for care, including out-of-pocket costs.

We remain committed to assisting our members in making informed and value-based healthcare decisions, providing for easier navigation of healthcare services and delivering a better healthcare experience.

Care Management and Wellness Products and Programs

We continue to expand our suite of integrated care management programs and tools. Availability of these programs and tools to our members may depend on the particular plan or product in which they participate. Our care management tools and programs are designed to increase quality and reduce medical costs for our members and help them make better decisions about their well-being as they navigate the healthcare system. Our digital engagement platform, Sydney Health, is designed to give our members access to personalized health and wellness resources, medical, pharmacy, dental and vision benefits details, and virtual care services, all in one place. Our care management, infertility services and maternity management programs serve as adjuncts to physician care. Through these programs, medical professionals help to educate participants regarding their care and condition. Our 24/7 NurseLine offers access to qualified, registered nurses to allow our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. Our Carelon Palliative Care Services subsidiary engages with members near end of life and/or requiring palliative care to manage serious illnesses and improve quality of life during a difficult time. With our integrated information systems and sophisticated data analytics, we help our members improve their compliance with evidence-based care guidelines, provide personal care notes that alert members to potential gaps in care, enable more prudent healthcare choices and assist in the realization of member out-of-pocket cost savings. Our employee assistance programs provide 24/7 telephonic support for personal and crisis events and provide resources such as counseling and referral assistance with childcare, health and wellness, financial issues, legal issues, adoption and daily living. We have a comprehensive behavioral health case management program supporting a wide range of members who are impacted by their behavioral health conditions, including specialty areas such as eating disorders, anxiety, depression and substance abuse. The program assists members and their families with obtaining appropriate behavioral health treatment, offering community resources, providing education and telephonic support, and promoting provider collaboration.

Healthcare Quality Initiatives

Increasingly, the healthcare industry is able to define quality healthcare based on effective, safe, equitable and affordable care in preventive health, and optimal care management for chronic disease. A key to our success has been our ability to develop partnerships by working with our network physicians, hospitals, and social resources providers to improve the quality outcomes of the healthcare and social impact services provided to our members, their families, and the community-at-large. Our ability to promote quality medical care and patient safety, address health-related social risks and advance health equity has been recognized by the National Committee for Quality Assurance ("NCQA"), the largest and most respected national accreditation program for managed care health plans, and our company was awarded the NCQA 2023-2024 Innovation Award for the advancement of better maternal and neonatal outcomes.

Several quality healthcare measures, including the Healthcare Effectiveness Data and Information Set ("HEDIS®"), have been incorporated into NCQA's accreditation processes. HEDIS® measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes, improving treatment for patients with heart disease, integration of behavioral health, and racial and ethnic stratification measurement to help close healthcare disparities.

Through our Carelon Medical Benefits Management, Inc. subsidiary, we promote appropriate, safe and affordable member care in areas including maternity care, imaging, sleep disorders, cardiac testing, oncology drugs and musculoskeletal procedures. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage provider communities and members in the more effective and efficient use of outpatient services and to promote the most appropriate use of clinical services to improve the quality of care.

We perform management review for home health and post-acute institutional services provided to Medicare members through our Carelon Post Acute Solutions, Inc. subsidiary, with the goal of ensuring they receive appropriate, high-quality

care and supporting their transition back into the home. Effective management of these services can help reduce preventable hospital admissions and readmissions, thereby improving healthcare outcomes for patients. Additionally, Carelon Medical Benefits Management, Inc. has developed programs to address healthcare quality by identifying and closing care gaps. A social determinants of health program screens our members for social needs and connects members to appropriate community resources to encourage better care outcomes. Both medical benefits management and post-acute solutions programs are examples of how we facilitate improvements in the quality of care provided to our members and promote cost-effective, affordable medical care.

The physical aspects of health have been traditionally the focus and the priority for healthcare. However, unique life circumstances and experiences impact every individual and their health. We seek to understand our members' health-related social needs to create a healthcare system that synchronizes care delivery for physical, behavioral, social and pharmacy needs. We have invested in a number of strategies to improve how we address health related social needs. We are advancing our efforts through consistent screening of our members for their social needs by using industry-standard tools such as the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences, co-creating social action plans with our members, connecting members to related social support services, and evaluating the entire process for continuous quality improvement. We have also implemented our "Food as Medicine" strategy across many of our lines of business to create interventions that not only prevent, manage, and treat diseases but also address food and nutrition insecurity among our members. We are committed to ensuring that all people, regardless of age, race or ethnicity, sexual orientation, gender identity, disability, and geographic or financial access can receive individualized care. Harnessing data gives a more complete picture of each member and their health needs and can help make healthcare more personalized and equitable. Strengthening communities has a positive effect on health; therefore, we value and nurture our local ties, which are a key component of our whole-health approach and drive us to work closely with community organizations that create support networks. Using our data, we also identify the resources needed to support local residents, including the people who we serve, to ensure those resources can better meet local needs.

BCBSA Licenses

We are a party to license agreements with the BCBSA that entitle us to the exclusive, and in certain areas, non-exclusive, use of the Blue Cross and Blue Shield names and marks in assigned geographic territories. BCBSA is a national association of independent Blue Cross and Blue Shield companies, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. Although previously we did not have a right to sell products and services using the BCBS names and marks outside of our exclusive service areas, under the terms of the *In re Blue Cross Blue Shield Antitrust Litigation* subscriber settlement agreement and release ("Subscriber Settlement Agreement") some large national employers with self-funded plans (specifically identified in the Subscriber Settlement Agreement), have a right to request a second Blue plan bid in addition to a bid from the local Blue plan, effective as of September 2024.

We are required to pay an annual license fee to the BCBSA based on enrollment and to comply with various requirements and restrictions regarding our operations and our use of the BCBS names and marks. These requirements and restrictions include, among other things: minimum capital and liquidity requirements; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA relating to enrollment and financial conditions; disclosures as to the structure of the BCBS system in contracts with third parties and in public statements; plan governance requirements; cybersecurity requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee's annual combined local net revenue, as defined by the BCBSA, attributable to healthcare plans and related services within its service areas must be sold, marketed, administered or underwritten under the BCBS names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services; governance requirements such as a requirement that we divide our Board of Directors into three classes serving staggered three-year terms; a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. In addition, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency or the appointment of a trustee or

receiver or the commencement of any action against us seeking our dissolution could cause a termination of our license agreements.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA. See Part I, Item 1A, "Risk Factors" in this Annual Report on Form 10-K for additional details on the impact if we were not to comply with these license agreements and Note 14, "Commitments and Contingencies – *Litigation and Regulatory Proceedings – Blue Cross Blue Shield Antitrust Litigation*," of the Notes to our Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K for additional information on the Subscriber Settlement Agreement.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. These laws and regulations, which can vary significantly from jurisdiction to jurisdiction, restrict how we conduct our businesses and result in additional burdens and costs to us. Further, federal and state laws and regulations are subject to amendments and changing interpretations in each jurisdiction. The application of these complex legal and regulatory requirements to the detailed operation of our businesses creates areas of uncertainty. In addition, there are numerous proposed healthcare laws and regulations at the federal and state levels, including single payer, Medicare for All and public option proposals, some of which could materially adversely affect our businesses if they were to be enacted.

Supervisory agencies, including federal and state regulators, departments of health and insurance and secretaries of state, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate our products and services in great detail;
- regulate, limit, or suspend our ability to market products, including participation in Medicare and the Public Exchanges;
- determine through a procurement process our ability to participate in certain programs, including state Medicaid programs;
- retroactively adjust premium rates;
- monitor our solvency and reserve adequacy;
- audit, and recover audit discrepancies, including risk adjustment data validation ("RADV") audits;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

To carry out these tasks, these government entities periodically examine our operations and accounts.

The health benefits business, pharmacy services, and related healthcare products and services businesses also may be adversely impacted by court and regulatory decisions that expand or invalidate the interpretations of existing statutes and regulations. It is uncertain whether we could recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation, regulation or court rulings. See Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

The Consolidation Appropriations Act of 2023

The Consolidated Appropriations Act of 2023 decoupled Medicaid eligibility redetermination from the COVID-19 Public Health Emergency, initially declared in January 2020. As a result, states were permitted to begin removing ineligible beneficiaries from their Medicaid programs starting April 1, 2023, and the majority of our Medicaid markets began doing so as of June 30, 2023. Although most states have completed this process, CMS has provided that states have until December 31, 2025, to complete these eligibility redeterminations. Since redeterminations resumed, we have continued to experience a decline in our Medicaid membership. We expect growth over time in our commercial plans, including through the Public Exchanges, as members who have lost Medicaid coverage in states where we offer commercial plans seek coverage elsewhere.

The Inflation Reduction Act of 2022

The Inflation Reduction Act of 2022 contains a variety of provisions that have impacted, and continue to impact, our business including extending the American Rescue Plan Act of 2021's enhanced Premium Tax Credits ("PTC") through 2025; imposing a new corporate alternative minimum tax; providing a one percent excise tax on repurchases of stock; allowing CMS to negotiate prices on a limited set of prescription drugs beginning in 2026; instituting caps on insulin cost sharing in Medicare; redesigning the Medicare Part D benefit; requiring drug manufacturers to pay rebates if prices increase beyond inflation; and delaying the implementation of the Trump Administration Medicare drug rebate rule to 2032. The extension of the enhanced PTC has allowed for growth in Individual Public Exchange enrollment and has supported continuity of coverage since Medicaid eligibility redeterminations resumed in 2023. If Congress does not act to extend the enhanced PTC, they will expire at the end of 2025, which could have a material adverse effect on our business and results of operations.

The Consolidated Appropriations Act of 2021

The Consolidated Appropriations Act of 2021 (the "2021 Appropriations Act") has impacted our business, including by imposing additional disclosure and reporting requirements related to broker compensation, mental health parity, pharmacy benefits and drug costs, as well as procedures and coverage requirements related to surprise medical bills, provider directory maintenance and continuity of care for certain patients. The requirements applicable to us under the 2021 Appropriations Act had varying effective dates beginning in December 2021.

The health plan price transparency regulations issued by the U.S. Departments of Health and Human Services ("HHS"), Labor, and Treasury (the "Tri-Agencies") pursuant to the 2021 Appropriations Act required us to begin disclosing certain pricing information regarding negotiated rates and historical payment information with providers in 2022. Additionally, as directed by law, we make available to members personalized out-of-pocket cost information and underlying negotiated rates.

In September 2024, the Tri-Agencies issued final regulations related to mental health parity that will require health plans to make administrative and operational changes to comply with these final regulations. Although some provisions became effective on January 1, 2025, additional guidance from the Tri-Agencies will be necessary to assess the full impact of these regulations on our operations and financial results. Litigation has been filed challenging the final regulation and is pending court action.

State Regulation of Insurance Companies and HMOs

Our insurance and HMO subsidiaries must obtain a certificate of authority and maintain that license in the jurisdictions in which they conduct business. The National Association of Insurance Commissioners ("NAIC") has adopted model regulations that, where adopted by states, require expanded governance practices, risk and solvency assessment reporting and the filing of periodic financial and operating reports. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. Health insurers and HMOs are subject to state examination and periodic license renewal.

In addition, we are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements, as well as restrictions on transactions between an insurer or HMO and its affiliates, and may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies. These holding company laws and regulations

generally require registration with applicable state departments of insurance and the filing of reports describing capital structure, ownership, financial condition, certain intercompany transactions, enterprise risks, corporate governance and general business operations. State insurance holding company laws and regulations require notice or prior regulatory approval of transactions including acquisitions, material intercompany transfers of assets, guarantees and other transactions between the regulated companies and their affiliates, including parent holding companies. Applicable state insurance holding company acts also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Dispositions of control generally are also regulated under the state insurance holding company acts.

The states of domicile of our regulated subsidiaries have statutory risk-based capital ("RBC") requirements for health and other insurance companies and HMOs based on the Risk-Based Capital (RBC) For Health Organizations Model Act. These RBC requirements are intended to assess the capital adequacy of health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. The law requires increasing degrees of regulatory oversight and intervention as a company's RBC declines. As of December 31, 2024, the RBC levels of our insurance and HMO subsidiaries exceeded all applicable mandatory RBC requirements. For more information on RBC capital and additional liquidity and capital requirements for a licensee of the BCBSA, see "Management's Discussion and Analysis of Financial Condition and Results of Operations – Liquidity and Capital Resources – *Capital Resources*," included in Part II, Item 7 of this Annual Report on Form 10-K.

Ongoing Requirements and Changes Stemming from the ACA

Since its enactment in 2010, the ACA has introduced new risks, regulatory challenges and uncertainties, has impacted our business model and strategy and has required changes in the way our products are designed, underwritten, priced, distributed and administered. We expect the ACA will continue to significantly impact our business and results of operations, including pricing, minimum medical loss ratios ("MLRs") and the geographies in which our products are available. We will continue to evaluate the impact of the ACA as any further developments occur.

We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, including evolving methodology for ratings and quality bonus payments. CMS also frequently proposes changes to its program that audits data submitted under the risk adjustment programs in ways that could increase financial recoveries from plans.

Certain significant provisions of the ACA include, among others:

- The creation of Public Exchanges for individuals and small group customers.
- The establishment of minimum MLR thresholds by line of business for the commercial market (which may be subject to more restrictive MLR thresholds under state regulations, such as those in New York). Medicare Advantage or Medicare Part D prescription drug plans that do not meet the mandated threshold will have to pay a minimum MLR rebate, will be subject to restricted enrollment if MLR is below the threshold for three consecutive years and are subject to contract termination if the plan's MLR is below the threshold for five consecutive years. In addition, state Medicaid programs are required to set managed care capitation rates such that a minimum MLR is projected to be achieved; however, states are not required to collect remittances if the minimum MLR is not achieved.

  Approximately 54.2% and 18.4% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2024. Approximately 52.3% and 18.0% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2023.
- The creation of an incentive payment program for Medicare Advantage plans. CMS developed the Medicare Advantage Star Ratings system, which awards between 1.0 and 5.0 Stars to Medicare Advantage plans based on performance in several categories, including quality of care and customer service. The Star Ratings are used by CMS to award quality-based bonus payments to plans that receive a rating of 4.0 or higher. The methodology and measures included in the Star Ratings system can be modified by CMS annually. Our 2024 Star Ratings, which are

used for payment year 2025, reflect that 53% of our Medicare Advantage members are enrolled in plans rated at least 4.0 Stars or higher. This was an increase over the original 2024 Star Rating of 34% that were released in October 2023 and were subsequently recalculated by CMS. CMS released our 2025 Star Ratings in October 2024, which will be used to determine our Medicare Advantage bonus payments in 2026. Our 2025 Star Ratings reflect that 38% of our Medicare Advantage members are enrolled in plans rated at least 4.0 Stars or higher. We expect this will result in a reduction to our 2026 operating revenue of approximately $183 million, net of offsets from contracting provisions. Further, we expect to mitigate the financial impact to our 2026 operating gain and net income per share through various strategies such as contract diversification, operating expense efficiencies, capital deployment alternatives and network enhancements.

- The implementation of a Medicare Advantage payment formula, which prevents reimbursement rates from increasing as much as otherwise would be expected.

We continue to participate in the Public Exchange in nearly all of our Anthem Blue Cross and Anthem Blue Cross and Blue Shield service areas. We anticipate growth in our Public Exchange membership as former Medicaid members, no longer eligible for Medicaid coverage, continue to seek alternative coverage options. Additionally, we are entering select service areas in Florida, Maryland, and Texas in 2025, using our Simply Healthcare and Wellpoint brands, and we are actively evaluating expansion opportunities in additional marketplaces beyond 2025. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows, and may require further adjustments to our rates and participation going forward. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact significant modifications to existing laws and regulations, including changes to available subsidies, taxes and fees.

Pharmacy Services and Drug Benefit Regulation

Pharmacy services, including pharmacy benefit managers, are regulated at both the federal and state levels and must comply with federal and state statutes and regulations governing a pharmacy benefit manager's business, including, but not limited to, pharmacy network restrictions and configurations, formulary management, affiliate pharmacy reimbursement, anti-steering to affiliated pharmacies, prohibition on pharmacy claim processing/transaction fees, pharmacy effective rates, guarantees and reconciliations, reimbursement pricing type mandates, purchase discount and/or rebate arrangements with drug manufacturers, advertising and licensing. Regulation in the states varies dramatically and ranges from licensure of pharmacy benefit managers as third-party administrators, licensure specifically as a pharmacy benefit manager, and licensure accompanied by additional disclosures and limitations of business practices to varying degrees.

Pharmacy benefit managers are also subject to continued changes in public policy, legislation, laws, and regulations relating to drug benefits and pharmacy services, which include, but are not limited to, (1) regulation of rebates from drug manufacturers that would require rebate dollars to be applied at the point-of-sale or passed through to the plan sponsor, (2) federal policy changes to set the prices for a subset of drugs covered under the Medicare program, (3) reforms to the Medicare drug benefit, such as beneficiary cost-sharing changes that aim to lower consumer costs and prohibit pharmacy benefit managers and their affiliates from deriving income based on the price of the drug, (4) attempts at both the federal and state levels to prohibit the use of spread pricing contracts in both the commercial and Medicaid markets, (5) prior authorizations of drugs, (6) transparency and public disclosure of costs and profits, (7) prohibiting exclusive specialty and mail pharmacy networks, (8) limiting pharmacy accreditation and credentialing requirements, (9) consumer choice/any willing provider requirements, and (10) prohibiting steering to affiliated pharmacies. These changes in public policy, legislation, laws, and regulations have the potential to have broad impacts on our pharmacy benefit management services and could materially adversely affect our business.

Our pharmacy services business includes home delivery and specialty pharmacies, infusion services, injectable therapies and clinic-based pharmacies, which must be licensed as pharmacies in the states in which they are located. Certain pharmacies must also register with the U.S. Drug Enforcement Agency (“DEA”) and individual state-controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our pharmacies are located, we may also be required to comply with certain laws and regulations in certain states into which one of our pharmacies delivers prescription drugs, including those requiring us to register with Boards of Pharmacy as a non-resident pharmacy. These non-resident states generally expect our pharmacies to follow the laws of the state in which the

pharmacies are located, but some non-resident states also require us to comply with certain of their pharmacy regulations as well. Additionally, pharmacies that participate in Medicare or Medicaid pharmacy networks are required to comply with applicable Medicare and Medicaid provider rules and regulations.

Privacy, Confidentiality and Data Standards Regulation

The federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the administrative simplification provisions of HIPAA impose a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses) and their business associates relating to the use, disclosure and safeguarding of protected health information. These requirements include uniform standards of common electronic healthcare transactions; privacy and security regulations; and unique identifier rules for employers, health plans and providers.

Also, the Health Information Technology for Economic and Clinical Health ("HITECH") Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations have imposed additional requirements on the use and disclosure of protected health information such as additional data breach notification and reporting requirements, contracting requirements for HIPAA business associate agreements, strengthened enforcement mechanisms and increased penalties for HIPAA violations. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directed HHS to develop a set of voluntary cybersecurity best practices for organizations in the healthcare industry, which were issued in 2018.

In addition, Public Exchanges are required to adhere to privacy and security standards with respect to personally identifiable information and to impose privacy and security standards that are at least as protective as those the Public Exchange has implemented for itself on insurers offering plans through the Public Exchanges and their designated downstream entities, including pharmacy services providers and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Furthermore, states have begun enacting more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency that may affect our privacy and security practices, such as state laws like the California Privacy Rights Act of 2020 that govern the use, disclosure and protection of member data and impose additional breach notification requirements. The NAIC has proposed revisions to the Privacy of Consumer Financial and Health Information Model Act, which, if implemented, would expand consumer privacy rights and place additional limitations on the use and disclosure of member data. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Complying with conflicting cybersecurity regulations and varying enforcement philosophies, which may differ from state to state, requires significant resources and may materially and adversely affect our ability to standardize our products and services across state lines.

Federal regulations have been finalized in the following areas that will continue to materially impact our operations:

- Federal regulations on data interoperability that require claims data to be made available to third parties unaffiliated with us that may not be HIPAA regulated; and
- Federal regulations requiring hospitals and health insurers to publish negotiated prices for services, including the health plan price transparency regulations issued in October 2020 by the U.S. Departments of Health and Human Services, Labor and Treasury (the "Health Plan Transparency Rule").

Beginning in July 2022, the Health Plan Transparency Rule required us to disclose, on a monthly basis, detailed pricing information regarding negotiated rates for all covered items and services between the plan or issuer and in-network providers and historical payments to, and billed charges from, out-of-network providers. Additionally, beginning in 2023, we were

required to make available to members personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered healthcare items and services, including prescription drugs. Effective January 1, 2024, this ongoing requirement has expanded to include all items and services.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor. ERISA regulates certain aspects of the relationships between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third-party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws, and the question of whether and to what extent ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies and HMOs can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company or HMO becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments are made retrospectively. Some states permit insurers or HMOs to recover assessments paid through full or partial premium tax offsets or through future policyholder surcharges. The amount and timing of any future assessments cannot be predicted with certainty; however, future assessments are likely to occur.

International Regulation

We have various international subsidiaries, which provide administrative and other services, that are subject to different, and sometimes more stringent, legal and regulatory requirements that vary widely by jurisdiction. In addition, our non-U.S. operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, including but not limited to, the Foreign Corrupt Practices Act and corresponding foreign laws governing anti-bribery, anti-corruption, anti-money laundering, data protection and privacy, employment, and other regulatory oversight initiatives.

Human Capital

The foundation of our strategy starts with our culture, and our associates are critical to fulfilling our purpose of improving the health of humanity. As of December 31, 2024, our employee population, including all full-time, part-time and temporary workers, consisted of approximately 104,200 individuals, 76,300 in the United States and 27,900 internationally. Ninety-nine percent of our total workforce is employed full-time, at least 33 hours a week.

We believe we have built a high-performance culture that enhances our ability to deliver on our commitments and long-term strategy, as well as guides us to address the challenges of today. We believe that our culture allows us to attract and retain talented and experienced individuals to support the communities we serve.

Because dedication to human capital management is a core component of our corporate governance, the Compensation and Talent Committee of our Board of Directors (our "Board") regularly reviews and discusses management's approach to talent acquisition and retention, and monitors our programs and practices related to workforce inclusion. Additionally, the Governance Committee of our Board has primary responsibility for monitoring our corporate social responsibility and environmental sustainability initiatives and performance. We provide the age, gender and racial and ethnic compositions of our U.S. work force in our annual Impact Report, which includes Equal Employment Opportunity Employer Information Report (EEO-1) data.

Culture, Engagement and Inclusion

Each year we conduct internal associate engagement surveys that provide our associates with an opportunity to share their opinions and experiences with respect to their roles, their teams and the Company, and we also offer online feedback

tools. Our management team reviews, monitors and analyzes associate feedback and acts on responses to identify opportunities to adjust our policies and benefits to improve our associates' experiences. In addition, in 2024, over 20% of our U.S. workforce participated in our Business Resource Groups, or BRGs, which provide associates meaningful opportunities to connect, collaborate and grow. These voluntary, associate-led communities, which are open to all of our associates, help to foster an environment of inclusivity, respect and collaboration. To further engage and reward our associates, we have an associate recognition program called IMPACT that empowers all associates to recognize their colleagues for their contributions to our Company and to celebrate both personal and professional milestones, whether recognition is for going "above and beyond" or simply to express thanks.

We are dedicated to attracting, developing, maintaining, and supporting an inclusive workforce that fosters a sense of belonging for individuals with a wide range of backgrounds, life experiences and cultures. We believe that these varied experiences enhance our connection with our members, enabling us to serve our members and communities more effectively and driving business impact. Our initiatives in this area are led by our Chief Talent Officer, and our workforce embodies a multitude of dimensions, including skills, experiences, age, tenure, gender, race, ethnicity, physical abilities and geographic location.

Fair Pay

We are committed to a fair pay workplace. We were in the first cohort of companies certified by the Fair Pay Workplace ("FPW"), an independent certification that takes a holistic approach to pay equity, partnering to design an annual pay equity action plan that includes a perpetual review of all positions, new hires and promotions to effect meaningful and measurable change. This independent certification is based on a set of publicly available rules and standards and the endorsed methodology of a group of leading experts from forward-thinking corporations, academia, human resources, data science and the legal field. After partnering with and overseeing our review process examining pay equity for cash compensation, including base and short-term incentives, in December 2024 FPW again validated our analysis of our U.S. associate population, which found that pay for women is 99.2% of men, and pay for people of color is 99.8% of white associates, after taking into account neutral, job related factors.

Talent Development and Retention

Growing, developing and retaining our talent internally is key to our succession plans and our ability to lead at our best every day. To inspire a high-performance culture, promote talent excellence and accelerate growth and innovation, we offer individual, career and leadership development opportunities, encouraging associates to continually learn, grow and expand their skill sets. We offer various instructor-led and virtual instructor-led programs and maintain a vast curriculum of relevant, on-demand learning and development resources. In 2024, we invested a significant amount in human capital development, averaging approximately 27 hours of training and development per associate.

Health, Wellness and Safety

We have the privilege of touching the lives of millions of people each day, starting with the health and safety of our own associates. To improve the health, wellbeing and safety of our associates, we offer a comprehensive compensation package, including competitive salaries, a 401(k) plan and medical, dental, vision and disability coverage. In addition, we offer our associates wellness and behavioral health programs and tools to help them get and stay healthy and more easily manage their work and personal lives. We have a mixed in-office, hybrid and remote workplace strategy, and we foster associate engagement through a variety of activities based in our key office locations.

Information About Our Executive Officers

The following sets forth certain information regarding our executive officers and Chief Accounting Officer as of February 1, 2025.

Name	Age	Position
Gail K. Boudreaux	64	President and Chief Executive Officer
Mark B. Kaye	45	Executive Vice President and Chief Financial Officer
Peter D. Haytaian	55	Executive Vice President and President, Carelon and CarelonRx
Charles M. Kendrick, Jr.	59	Executive Vice President and President, Commercial Health Benefits
Ratnakar V. Lavu	54	Executive Vice President and Chief Digital and Information Officer
Felicia F. Norwood	65	Executive Vice President and President, Government Health Benefits
Ronald W. Penczek	60	Chief Accounting Officer and Controller

Ms. Boudreaux has been serving as our President and Chief Executive Officer and as a Director of the Company since November 2017. Prior to joining us, she served as Chief Executive Officer of GKB Global Health, LLC (healthcare consulting firm) from 2015 to November 2017. Prior thereto, Ms. Boudreaux was Executive Vice President of UnitedHealth Group Incorporated ("UHGI") (diversified healthcare company) from 2008 to 2015. She also served as Chief Executive Officer of UnitedHealthcare (managed healthcare company), a subsidiary of UHGI from 2011 to 2014 and as President of the Commercial Business of UnitedHealthcare from 2008 to 2010. Before joining United Healthcare, she worked at Health Care Service Corporation ("HCSC") (health insurance company) as Executive Vice President of External Operations from 2005 to 2008 and President of Blue Cross and Blue Shield of Illinois from 2002 to 2005. Before joining HCSC, Ms. Boudreaux held various positions at Aetna, Inc. ("Aetna") (managed healthcare company), including Senior Vice President, Group Insurance.

Mr. Kaye has been serving as our Executive Vice President and Chief Financial Officer since November 2023, having joined us in September 2023 as our Chief Financial Officer Designate. Prior to joining us, he served as the Executive Vice President and Chief Financial Officer of Moody's Corporation ("Moody's") (credit rating and research company) from April 2021 to September 2023, with responsibility for all global finance activities across the company and as Senior Vice President - Chief Financial Officer from August 2018 to April 2021. Prior to Moody's, he served as Senior Vice President and Head of Financial Planning and Analysis at Massachusetts Mutual Life Insurance Company ("MassMutual") (financial services company) from February 2016 until July 2018, and Chief Financial Officer of MassMutual U.S. from July 2015 to February 2016. Prior to that, Mr. Kaye served as Chief Financial Officer and Senior Vice President, Retirement Solutions, at Voya Financial (formerly ING U.S.) (institutional asset manager) from 2011 to 2015. Leading up to that appointment, Mr. Kaye held various senior financial and risk reporting positions at ING U.S. and ING Group. Prior to that, Mr. Kaye worked in the investment banking division of Credit Suisse First Boston.

Mr. Haytaian has been serving as our Executive Vice President and President of Carelon and CarelonRx since October 2021. Prior to his current role, he was Executive Vice President and President of the Commercial & Specialty Business Division beginning in April 2018. From June 2014 until April 2018, Mr. Haytaian held the position of Executive Vice President and President of the Government Business Division. He joined the Company in 2012 through the acquisition of Amerigroup Corporation ("Amerigroup") and served as President of our Medicaid business from 2013 until 2014. From 2005 to 2013, Mr. Haytaian held various leadership positions with Amerigroup, including Chief Executive Officer of the North Region for its Medicaid business from 2012 until 2013. Mr. Haytaian has extensive experience leading Medicare and Medicaid programs both at Amerigroup and, prior thereto, with Oxford Health Plans, Inc.

Mr. Kendrick has been serving as our Executive Vice President and President of our Commercial Health Benefits since October 2021. From January 2021 until October 2021, Mr. Kendrick served as President of our Commercial Business West Markets (California, Colorado, Indiana, Kentucky, Missouri, Nevada, Ohio and Wisconsin). Mr. Kendrick has been with the Company since 1995, and has held various leadership roles across the organization, including serving as President, Anthem National Accounts/Central Markets from 2015 until January 2021 and President of National Accounts and General Manager for Anthem Blue Cross and Blue Shield of Georgia from 2010 until 2015.

Mr. Lavu has been serving as our Executive Vice President and Chief Digital and Information Officer since February 2024. Prior to joining us, he served as Global Chief Digital Information Officer of Nike, Inc. ("Nike") (retailer) from July 2019 to February 2023. Prior to Nike, he served as Chief Technology Officer/CIO of Kohl's Corporation ("Kohls") (retailer) from March 2016 to June 2019, and he held other various roles at Kohl's beginning in 2011, including Executive Vice President, Digital Technology, and Senior Vice President of Digital Innovation. Prior to Kohl's, Mr. Lavu served as Chief Technology Officer at Redbox Automated Retail, LLC (retailer) from October 2009 to October 2011.

Ms. Norwood has been serving as our Executive Vice President and President of our Government Health Benefits since June 2018. Prior to joining us, she was Director of The Department of Healthcare and Family Services for the State of Illinois from 2015 to June 2018. Prior to that appointment, Ms. Norwood held various leadership roles at Aetna, with her most recent role as President of the Mid-America Region for Aetna from 2010 until 2013.

Mr. Penczek has been serving as our Controller since November 2015 and as our Chief Accounting Officer since December 2015. He served as our Vice President and Corporate Controller from 2013 to 2015. Prior to that appointment, Mr. Penczek served as Vice President and Assistant Controller from 2008 to 2012 and in various other roles in our finance department from 2005 until 2008. Before joining us in 2005, Mr. Penczek was a Staff Vice President with CNA Insurance from 2000 to 2005 and held various positions at PricewaterhouseCoopers LLP from 1992 to 2000, including as a Manager.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended (the "Exchange Act")) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission (the "SEC"). The SEC maintains a website that contains reports, proxy and information statements and other information regarding issuers at www.sec.gov. Our website is www.elevancehealth.com. We have included our website address in this Annual Report on Form 10-K as a textual reference only. The information contained on, or accessible through, our website is not incorporated into this Annual Report on Form 10-K or any of our other SEC filings. We make available through our website, free of charge, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our website our Corporate Governance Guidelines, our Code of Conduct and the charter of each standing committee of our Board of Directors. In addition, we intend to disclose on our website any amendments to, or waivers from, our Code of Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange. Elevance Health, Inc. is an Indiana corporation incorporated on July 17, 2001.

ITEM 1A. RISK FACTORS.

In evaluating our business, the risks described below, as well as the other information contained in this Annual Report on Form 10-K, should be carefully considered. Any one or more of such risks could materially and adversely affect our business, financial condition, results of operations and stock price and could cause our actual results of operations and financial condition to vary materially from past or anticipated future results of operations and financial condition. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect us.

BUSINESS RISKS

If we fail to appropriately predict, price for and manage healthcare costs, the profitability of our products and services could decline, which could materially adversely affect our business, cash flows, financial condition and results of operations.

Our profitability depends on accurately predicting and pricing for healthcare costs. Profitability is also dependent on our ability to manage future healthcare costs through medical management, product design, negotiation of favorable provider contracts and underwriting criteria. Total healthcare costs are affected by the type, number and unit cost of individual services rendered. Numerous factors affecting healthcare costs may adversely affect our ability to predict and manage such costs, and may impact our business, cash flows, financial condition and results of operations. These factors include, among others: changes in healthcare practices; healthcare utilization patterns; demographic characteristics including the aging population; previously uninsured members entering the healthcare system; short and long-term risks associated with our members' lifestyle decisions; medical cost inflation; increased labor costs; provider and member fraud; evolution of new technologies, drugs and treatments; increased cost of individual services; increased number and cost of prescription drugs; direct-to-consumer marketing by drug manufacturers; clusters of high cost cases; increased use of services, including resulting from pandemics, large-scale medical emergencies, increasing natural

disasters in connection with climate change, geopolitical instability and other public health crises; and new mandated benefits and treatment guidelines and changes to other regulations impacting our business.

Our estimates of future benefit cost projections involve extensive judgment and are subject to considerable inherent variability. Slight differences between our predicted and actual medical costs or utilization rates as a percentage of premium revenues can result in significant changes in our results of operations. Generally, our premiums on commercial policies and Medicaid contracts are fixed for a 12-month period and are determined based on data from several months prior to the commencement of the premium period. Our revenue from Medicare policies is based on bids submitted to CMS six months prior to the start of the contract year. CMS has explicit gain and loss margin requirements within the bids, as well as contract-specific federal MLR annual requirements. Accordingly, the costs we incur in excess of our benefit cost projections cannot be recovered in the contract year through higher premiums. Existing Medicaid contract rates are often established by the applicable state, and our actual costs may exceed those rates. Many factors, including those discussed above, have caused, and may in the future cause, actual costs to exceed those estimated and reflected in our commercial premiums and Medicare and Medicaid bids.

We participate in the Public Exchange in many of the states where we offer Medicaid health plans. The Public Exchange markets in general are highly volatile and unpredictable from year to year. We develop each state's Public Exchange market premium rates during the spring of each year for policies effective in the following calendar year. Legislation, regulation enforcement activity and judicial decisions that cause the Public Exchange to operate in a manner different than we projected in setting premium rates, including the potential expiration of enhanced PTCs at the end of 2025, could affect our results. In addition, any variation from our cost expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates, could have a material adverse effect on our results of operations, financial position, and cash flows.

Although federal and state premium and risk adjustment mechanisms could help offset health benefit costs above our projections if the assumptions we use to set our premium rates are significantly different than actual results, our results of operations and financial condition could still be adversely affected. The reserves that we establish for health insurance policy benefits and other contractual rights and benefits are based on assumptions concerning a number of factors, including trends in healthcare costs, expenses, general economic conditions and other factors. To the extent the actual claims experience is unfavorable compared to our underlying assumptions, our incurred losses would increase, and future earnings could be adversely affected. Further, if we are unable to provide higher quality outcomes and better experiences through the development and expansion of our value-based care products at lower costs or to integrate our care delivery model, our results of operations, financial position and cash flows may be adversely impacted.

Pharmaceutical products and services are a significant component of our healthcare costs. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, existing prices, geographical variation in utilization of new FDA-approved pharmaceuticals and new FDA-approved indications for existing pharmaceuticals, and changes in discounts.

In addition to the challenge of managing healthcare costs, we face pressure to contain premium rates. Our customers may renegotiate their contracts to seek to contain their costs or may move to a competitor to obtain more favorable premiums. Public Exchange plan selection by our customers is also highly price sensitive. Further, federal and state regulatory agencies may restrict or prevent entirely our ability to implement changes in premium rates. A limitation on our ability to increase or maintain our premium or reimbursement levels or a significant loss of membership resulting from our need to increase or maintain premium or reimbursement levels could adversely affect our business, cash flows, financial condition and results of operations.

A significant reduction in the enrollment in our health benefits programs, pharmacy services or diversified products and services, particularly in states where we have large regional concentrations, could have an adverse effect on our business, cash flows, financial condition and results of operations.

A significant reduction in the number of enrollees in our health benefits programs, pharmacy services, or diversified products and services could adversely affect our business, cash flows, financial condition and results of operations. Factors that have contributed, and may continue to contribute, to a reduction in enrollment include: reductions in workforce by existing customers; a reduction in Medicaid membership due to the end of the temporary suspension of eligibility redetermination for Medicaid recipients in response to the COVID-19 pandemic; a general economic upturn that results in fewer individuals being eligible for Medicaid programs; a general economic downturn that results in business failures and high unemployment rates; employers no longer offering certain healthcare coverage as an employee benefit or electing to offer coverage on a voluntary, employee-funded basis; participation on Public Exchanges; federal and state regulatory changes; failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; negative publicity and news coverage; and, failure to attain or maintain nationally recognized accreditations.

The states in which we operate with the largest concentrations of revenues include California, Virginia, New York, Ohio, Indiana, Florida, Texas and Georgia. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of state-specific or regional economic downturns or healthcare coverage changes impacting these states. If any such negative economic conditions do not improve, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

A cyber-attack or other privacy or data security incident sustained by us or third parties we rely on could result in an unauthorized disclosure of sensitive or confidential information, cause a loss of data, disrupt our operations, give rise to remediation or other expenses, expose us to liability under our contracts, federal, state and international laws, and subject us to litigation and investigations, which could have an adverse effect on our business, reputation, cash flows, financial condition and results of operations.

As part of our normal operations, we collect, store, process, retain and analyze certain sensitive and confidential information, including personal information subject to privacy, security and data breach notification requirements. Some of the data we process, store and transmit is outside of the U.S. due to the structure of our information technology systems and our internal business operations. We are subject to a variety of continuously evolving federal, state and international laws and rules regarding collection, dissemination, receipt, maintenance, protection, use, transmission, disclosure, privacy, confidentiality, security, availability, integrity, creation, processing and disposal of sensitive or confidential information that, depending on the specific business and intended data use, include without limitation, HIPAA's privacy and security rules, HIPAA's HITECH rule, the Gramm-Leach-Bliley Act, the General Data Protection Regulation and numerous state laws governing personal information, including the California Consumer Privacy Act, as amended by the California Privacy Rights Act. Regulators are also imposing new and greater monetary fines or penalties for privacy violations, and jurisdictions where we operate have passed, and continue to propose, data privacy legislation and/or regulations related to Artificial Intelligence ("AI"). We have programs in place to detect, contain and respond to data, privacy and security incidents and provide employee awareness training regarding phishing, malware, and other risks to protect against privacy and cybersecurity incidents. Our facilities and systems, and those of our third-party service providers, including our business associates, are regularly the target of, and may be vulnerable to, cyber-attacks, security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors, negligent or wrongful conduct by associates or others with permitted access to our systems and information, or other threats or catastrophic events. Additionally, there have been, and may in the future be, heightened vulnerabilities due to our remote or varied geographical workforce operations.

We cannot ensure that we or our third-party service providers will be able to identify, prevent or contain the effects of cyber-attacks or other cybersecurity risks that bypass our or their security measures or disrupt our or their information technology systems or business. Hardware, software or applications we develop or procure from third parties may contain defects in design, manufacturer defects or other problems that could unexpectedly compromise information security. In addition, because the techniques used to obtain unauthorized access, disable, disrupt or degrade service or sabotage systems change frequently, are becoming increasingly sophisticated (in part due to the use of evolving technologies), and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques and threats, timely discover or counter them or implement adequate preventative measures. Viruses, worms, malicious software programs or other unauthorized methods of acquiring data may be used to attack our systems or otherwise exploit any security vulnerabilities which may cause system disruptions or shutdowns, or may cause personal, proprietary or confidential information to be disclosed, misappropriated or compromised. We have business continuation and resiliency plans which are maintained, updated and tested regularly in an effort to successfully contain and remediate potential disruptions or cyber events, but there is no guarantee that such efforts will be effective. If those efforts are not effective, the functionality of our information technology systems or those of third parties could be interrupted. Cybersecurity and the continued development and enhancement of our controls, processes and practices designed to protect our systems, computers, software, data and networks from attack, damage and unauthorized access remain a priority for us.

We have been, and may in the future be, subject to litigation and governmental investigations related to cyber-attacks, privacy incidents and security breaches. Any such future litigation or governmental investigation could divert the attention of management from the operation of our business, result in reputational damage and have a material adverse impact on our business, cash flows, financial condition, and results of operations. Moreover, our programs to detect, contain, and respond to data security incidents as well as contingency plans and insurance coverage for potential liabilities of this nature may not be sufficient to cover all claims and liabilities.

Noncompliance with any privacy, security or data protection laws and regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the misappropriation, exfiltration, theft, loss or other unauthorized disclosure or use of, or access to, sensitive or confidential information, whether by us or by one of our third-party service providers or their vendors, previously have and could in the future require us to expend significant resources to continue to modify or enhance our protective measures and to remediate any damage. In addition, this could negatively affect our operations, cause system disruptions, damage our reputation, cause membership losses and contract breaches, expose us or our members to the risk of financial or medical

identity theft, and result in regulatory enforcement actions, material fines and penalties, litigation or other actions that could have a material adverse effect on our business, cash flows, financial condition and results of operations.

If we fail to responsibly use and protect data, or if such data is found to be inaccurate or unreliable, our business and customers could suffer adverse consequences.

We use de-identified and aggregated data to create analytic models designed to predict, and potentially improve, outcomes and patient care. The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information is regulated at the federal, state, international and industry levels and requirements are also imposed on us and vendors through contracts with clients. We are also subject to various other consumer protection laws that regulate our communications with customers. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is designed to protect credit card account data as mandated by payment card industry entities. In addition, more jurisdictions are regulating the collection, use and transfer of data across borders. These laws, rules, regulations and contractual requirements are subject to change, and the regulatory environment surrounding data protection and privacy is becoming more onerous. Compliance with existing or new privacy, security, technology or data protection laws, regulations and requirements may result in increased enforcement and costs, and may constrain or require us to alter our business model or operations.

Further, if the data we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could experience failures in our technology products; lose existing customers; have difficulty attracting new customers; experience problems in determining medical cost estimates and establishing appropriate pricing; have difficulty preventing, detecting and controlling fraud; have disputes with customers, physicians and other healthcare professionals; become subject to regulatory sanctions, penalties, investigations or audits; incur increases in operating expenses; or suffer other adverse consequences.

There are various risks and conditions associated with participating in Medicare and Medicaid programs, including payment rates, processes and timelines that are determined by the government, compliance with government contract requirements and regulatory oversight.

We contract with various federal and state agencies, including CMS, to provide managed health benefits services, such as Medicare Advantage, Medicare Part D, Medicare Supplement, Medicaid, TANF, SPD, LTSS, CHIP, Medicaid expansion programs and various specialty programs, products and services. We also provide various administrative services for other entities offering medical and/or prescription drug plans to their Medicaid or Medicare eligible members, and we offer employer group waiver plans which provide medical and/or prescription drug coverage to retirees. We also participate in programs in several states for the care of dual-eligible members. Changes in existing laws or regulations applicable to these programs, or their interpretations, are difficult to predict and could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Revenues from the Medicare and Medicaid programs are determined, in whole or in part, by the federal government and/or applicable state governments, and base premium rates paid by each state or federal agency differ depending upon a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Rates may be affected by federal and state budgetary constraints. Certain state contracts are subject to cancellation in the event of the unavailability of state funds. Additionally, ongoing CMS changes to the calculation of risk in the Medicare Advantage program may impact our revenue. For example, CMS made significant changes to the structure of the hierarchical condition category model in version 28, which may impact risk adjustment factor ("RAF") scores for a larger percentage of Medicare Advantage beneficiaries and could result in changes to beneficiary RAF scores with or without a change in the patient's health status. The federal government or any state in which we operate could decrease rates paid to us, pay us less than the amount necessary to keep pace with our cost trends, cancel our contracts retroactively or seek an adjustment to previously negotiated rates. In addition, various states' Medicare-Medicaid dual-eligible plans are still subject to uncertainty surrounding payment rates and other requirements, which could affect where we seek to participate in these programs. For example, CMS will require in future years that health plans offering certain dual-eligible products must also align with integrated Medicaid products in the same service area. Some states are also requiring companies to offer Medicaid within a state and are conducting competitive bid processes to qualify to offer dual-eligible products. An unexpected reduction in payments, inadequate government funding or significantly delayed payments for these programs may adversely affect our business, cash flows, financial condition and results of operations.

Other potential risks associated with Medicare Advantage and Medicare Part D plans include increased medical or pharmaceutical costs, data corrections identified as a result of ongoing auditing and monitoring activities, potential uncollectability of receivables resulting from processing and/or verifying enrollment, inadequacy of underwriting assumptions, inability to receive and process correct information (including inability due to systems issues by the federal government, the applicable state government or us), uncollectability of premiums from members and limited enrollment periods. Actual results may be materially

different than our assumptions and estimates and could have a material adverse effect on our business, financial condition and results of operations.

Our contracts with CMS and state governmental agencies contain certain provisions regarding data submission, risk adjustment, provider network and directory maintenance, quality measures, claims payment, timely and accurate processing of appeals and grievances, oversight of service providers, encounter data, continuity of care, call center performance and other requirements specific to federal and state program regulations. We have been subject in the past, and may again be in the future, to administrative actions, fines, penalties, liquidated damages or retrospective adjustments in payments made to our health plans as a result of a failure to comply with these requirements, which has impacted, and in the future could impact, our profitability. We have experienced retroactive rate adjustments by certain state Medicaid agencies in the past, and such rate adjustments may occur in the future. Further, our state Medicaid contracts have not always been renewed, we have not always been awarded new contracts as a result of the competitive procurement process, and in some cases, we have lost members under existing contracts as a result of a post-award challenge by unsuccessful bidders, each of which could take place in the future and have a material adverse effect on our business, cash flows, financial condition and results of operations.

The Star Rating System utilized by CMS to evaluate Medicare Advantage Plans may have a significant effect on our revenue, as higher-rated plans tend to experience increased enrollment, plans with a Star Rating of 4.0 or higher are eligible for quality-based bonus payments and plans with a Star Rating of 5.0 can market to and enroll members year-round. CMS continues to change its rating system to make achieving and maintaining a 4.0 or higher Star Rating more difficult. CMS released our 2025 Star Ratings in October 2024, which will be used to determine our Medicare Advantage plans' quality bonus payments in 2026. Based on our membership at September 1, 2024, 38% of our Medicare Advantage members were in plans with 2025 Star Ratings of at least 4.0 Stars, compared to 53% of our Medicare Advantage members being in plans with 2024 Star Ratings of at least 4.0 Stars (based on our 2024 Star Ratings, as recalculated by CMS). This change in our 2025 Star Ratings is expected to negatively impact our Medicare quality bonus payments, plan level rebates and operating revenue beginning in 2026, and our enrollment may be negatively impacted as consumers seek higher rated plans. Further, if we do not improve our Star Ratings, or if quality-based bonus payments are reduced or eliminated, we will experience further negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our ability to expand our business, our membership levels, results of operations, financial condition and cash flows. Similarly, if we fail to meet or exceed any performance standards imposed by state Medicaid programs in which we participate, we may not receive performance-based bonus payments or may incur penalties.

In addition, our failure to comply with federal and state healthcare laws and regulations applicable to our participation in Medicaid and Medicare programs, including those directed at preventing fraud, abuse and discrimination, could result in investigations, litigation, fines, restrictions on, or exclusions from, program participation, or the imposition of corporate integrity agreements or other agreements with a federal or state governmental agency, any of which could adversely impact our business, cash flows, financial condition and results of operations.

We are periodically subject to government audits, including CMS RADV audits of our Medicare Advantage Plans to validate diagnostic data, patient claims and financial reporting, and audits of our Medicare Part D plans by the Medicare Part D Recovery Audit Contractor (“RAC”), as well as state Medicaid RAC programs. Certain of our contracts currently have pending RADV audits by CMS and the HHS Office of Inspector General that are awaiting CMS finalization. In addition, we routinely perform ordinary course reviews of, among other things, our Medicare Advantage data submitted to CMS. These governmental audits, or changes in how these audits are conducted, including changes that may result from the final RADV Audit rule that was issued in 2023, and our internal reviews, have, and could in the future, result in reports or disclosures for prior, current or future filing years to federal or state regulatory agencies, submission of data corrections, and/or significant adjustments in payments made to our health plans and future Medicare Advantage bids, which could adversely affect our financial condition and results of operations. Governmental regulators and agencies continue to heighten their scrutiny of business and reporting practices within the health services industry with respect to risk adjustment and claims payment. Additionally, state regulators are increasingly conducting audits to assess the quality of services we provide to our Medicare members. If we fail to report and correct errors discovered through our own auditing procedures, during a RADV or RAC audit or during state regulatory audits, or otherwise fail to comply with applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions, which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations. In addition, price transparency initiatives, such as the Health Plan Transparency Rule, may impact our ability to obtain or maintain favorable contract terms. For example, hospitals are required to publish online payer-specific negotiated charges for each item or service the hospital provides.

Our Medicare and Medicaid contracts are also subject to various MLR rules, including minimum MLR thresholds, rebate requirements and audits, which could adversely affect our membership and revenues if any of our state Medicare or Medicaid plans do not meet an applicable minimum MLR threshold. If a Medicare Advantage, MMP or Medicare Part D contract pays minimum

MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

A change in our healthcare product mix may impact our profitability.

Our healthcare products that involve greater potential risk generally tend to be more profitable than administrative services products and those healthcare products where the employer groups assume the underwriting risks. Individuals and small employer groups are more likely to purchase our higher-risk healthcare products because such purchasers are generally unable or unwilling to bear greater liability for healthcare expenditures. Typically, government-sponsored programs also involve our higher-risk healthcare products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our cash flows, financial condition and results of operations.

If we fail to develop and maintain satisfactory relationships with hospitals, physicians, pharmacy service providers and other healthcare providers, our business, cash flows, financial condition and results of operations may be adversely affected.

Our profitability is dependent in part upon our ability to contract on favorable terms with hospitals, physicians, pharmacy services providers and supply chain partners and other healthcare providers. These partners may elect not to contract with us, and the failure to secure or maintain cost-effective contracts on competitive terms may result in a loss of membership or higher medical costs, which could adversely affect our business. In addition, consolidation among healthcare providers, Accountable Care Organizations practice management companies, and other organizational structures that physicians, hospitals and other care providers choose, as well as the ability of larger employers to contract directly with providers, has changed and may continue to change the way that these providers interact with us and may alter the competitive landscape overall. Such organizations or groups of physicians may compete directly with us or be owned by one of our competitors, which may impact our relationship with these providers or affect the way that we price our products and estimate our costs. Such competition may require us to incur costs to change our operations, which could adversely affect our business, cash flows, financial condition, and results of operations.

Our inability to contract with providers, providers attempting to use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, the departure of prominent network providers or provider groups to competitors, or the inability of providers to provide adequate care could adversely affect our business. In addition, we do not have contracts with all providers that render services to our members and, as a result, may not have a pre-established agreement about the amount of compensation those out-of-network providers will accept for the services they render. State and federal laws, such as the No Surprises Act, define the compensation that must be paid to out-of-network providers in certain scenarios, and related litigation has lessened the weight of the Qualifying Payment Amount during independent dispute resolution processes, which may result in an increase in rates we must pay to out-of-network providers. Both our lack of contracts with certain providers and the development of new federal and state laws could result in significant litigation or arbitration proceedings, to the extent a provider attempts to obtain payment from our members for the difference between the amount we have paid and the amount they have charged, or other increases in rates paid to out-of-network providers.

We are dependent on the success of our relationships with third parties for various services and functions.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Certain of these third parties provide us with significant portions of our business infrastructure and operating requirements. For example, a single vendor can provide to us a wide range of technology infrastructure services, such as end user (help desk and field support), data center, mainframe, payment card handling, storage and database services and multi-cloud management services, and we are subject to the risks of any operational failure, termination or other restraints in such an arrangement. We could become overly dependent on key vendors, which could cause us to lose core competencies. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruptions or unavailability, reduced service quality and effectiveness, increased or duplicative costs or an inability to meet our obligations to our customers. In addition, we may also have to seek alternative service providers, which may be unavailable or only available on less favorable contract terms or with more difficult integration hurdles. Any of these outcomes could adversely affect our business, reputation, cash flows, financial condition and operating results.

Our pharmacy services business would be adversely affected if we are unable to contract on favorable terms with third-party vendors, including pharmaceutical manufacturers. We delegate certain pharmacy benefit manager services, including, but not limited to, claims adjudication, pharmacy network administration, rebate administration, advanced home delivery back-end dispensing, and customer service, to CVS pursuant to the CVS Agreement. If CVS fails to provide pharmacy benefit manager services as contractually required, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and results of operations. Additionally, we may not maintain favorable terms and conditions, including financial terms, to compete in the market. For additional information on the CVS Agreement, see “Business - Product and Service Descriptions,” in Part I, Item 1 of this Annual Report on Form 10-K.

The failure to properly maintain the integrity or availability of our data, or to successfully maintain, protect and upgrade our information systems could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses, including those that we have acquired as a result of our merger and acquisition activities. Our information systems require an ongoing investment, commitment of significant resources to maintain, integrate, upgrade, enhance and expand existing systems, and development of new systems to keep pace with continuing changes in information processing technology, emerging cybersecurity risks, changing customer preferences, evolving industry and regulatory standards and legal requirements, including as a result of the ACA, the Health Plan Transparency Rule, the 2021 Appropriations Act and federal data interoperability regulations. In addition, we may obtain significant portions of our systems-related or other services from independent third parties (and their vendors), which may make our operations vulnerable if such third parties fail to perform and oversee adequately. Further, unauthorized third parties present additional risk, including by propagating misinformation related to products, business and the health industry.

Failure to adequately implement, consolidate, integrate, streamline, maintain and upgrade effective and efficient information systems, including those powered by or incorporating AI, with sufficiently advanced technological capabilities could result in investigations, audits, fines and penalties, competitive and cost disadvantages to us compared to our competitors, contractual damages, and diversion of management's time, and could have a material adverse effect on our business, financial condition and results of operations. Failure or disruption of our performance of, or our ability to perform, key business functions, including as a result of the unavailability or cyber-attack of our information technology systems or those of third parties (including cloud service providers), could decrease response times, lower levels of service satisfaction and harm our reputation and brand. Our systems interface with and depend on third-party systems, hardware, infrastructure and cloud technologies, and we could experience service denials if demand for such service exceeds capacity, or these systems fail or experience interruption. From time to time, we update, transition, acquire, or expand use of our and third-party information technology systems, which may result in heightened vulnerability. Some third-party systems that are necessary for the operation of our business processes are maintained outside of our control but would impact our business operations if compromised as a result of a cyber-attack. Despite our adoption and continued enhancement of business continuity and disaster recovery strategies, there is no guarantee that such efforts will be effective, which could interrupt the functionality of our information technology systems or those of third parties. Our failure to implement adequate business continuity and disaster recovery strategies could significantly reduce our ability to provide products and services to our customers and members, which could have a material adverse effect on our business and results of operations.

In addition, connectivity amongst technologies is becoming increasingly important, with recent trends bringing greater consumer engagement in healthcare; therefore, the pace at which our customers will need enhanced technologies with sophisticated applications for mobile interfaces, including tools and products that leverage AI to improve the customer experience, will quicken. We anticipate that fast-evolving AI technologies will play an increasingly significant role in our information systems and technology products. If the information systems we rely upon to run our business were found to be inaccurate or unreliable or if we fail to adequately maintain, upgrade, enhance, expand and protect our information systems, security controls and data integrity effectively, we could experience problems in determining medical cost estimates and establishing appropriate pricing and reserves, have disputes with customers and providers, lengthen the pace of integration activities or otherwise delay the launch of acquired products, face regulatory problems, including sanctions and penalties, incur increases in operating expenses or suffer other adverse consequences, including a decrease in membership.

We are subject to risks associated with our use of AI, which could adversely affect our business, reputation or financial results.

As part of our operations, we are making investments in certain AI administrative tools and solutions to enhance our operations and positively impact the experience of our members, and we continue to explore further innovation using AI. The rapid advancement of these technologies presents opportunities for us, but there are risks associated with the development and deployment of AI, and there can be no assurance that our usage of AI will enhance our operations. We have developed and implemented policies and procedures intended to promote and sustain responsible design, development, and use of AI. Our AI-related efforts may give rise to risks related to accuracy, harmful bias, discrimination, intellectual property infringement, data privacy, and cybersecurity, among others. In addition, we may be subject to new or enhanced governmental or regulatory scrutiny, litigation or other liability and ethical concerns, and negative consumer perceptions as to the use of automation and AI, or other complications that could adversely affect our business, reputation, or financial results. Any inadequacy in or failure to comply with our responsible use of AI policies and procedures or emerging laws, regulations and standards governing AI use could cause our technology not to operate as intended or to produce outcomes that could have a material and adverse effect on our business, reputation, results of operations, financial position and cash flows.

We are subject to risks associated with pandemics, like the COVID-19 pandemic, as well as other extreme events, large-scale medical emergencies and public health crises, which could have a material adverse effect on our business, results of operations, and financial condition and financial performance.

A pandemic or other large-scale medical emergency or public health crisis, such as the COVID-19 pandemic, referred to collectively as "public health crises," may cause illness, death, quarantines, business and school shutdowns, reductions in business activity, travel and financial transactions, unemployment, inflation, labor shortages, supply chain interruptions, disruptions in public and private infrastructure and overall economic and financial market instability. The following are some risks that we could experience as a result of future public health crises, all of which could increase our costs, impair our ability to provide services, and have a material adverse effect on our business, cash flows, financial condition and results of operations:

- Increased healthcare costs due to higher utilization rates of medical facilities and services and behavioral health services, increased labor costs resulting from labor shortages and increases in medical expenses and associated hospital and pharmaceutical costs, including testing, treatment and the administration of vaccines and other therapeutics and costs due to care deferred during the public health crisis, which may lead to additional care resulting from missed treatments.
- Increased estimation uncertainty for our claims liability, as well as decreased predictability of Medicare and Medicaid rates due to changes in utilization of medical facilities and services, medical expenses and other costs.
- A reduction in enrollment in our health benefits, pharmacy services, or other healthcare services and products or a change in membership mix to less profitable lines of business by existing customers due to reductions in workforce and other impacts of an economic downturn.
- Cash flow volatility or shortfalls caused by delayed, delinquent or non-collectable payments.

If any future public health crisis occurs and continues for a prolonged period, these risks could be exacerbated and cause further impact to our business and operations. Additionally, other extreme events such as natural disasters, war, terrorism, increased crime, civil unrest and sanctions could create public health crises, operations disruptions or otherwise have a material adverse effect on our business, cash flows, financial condition and results of operations. In the event of a public health crisis, we may need to make temporary policy changes, such as waiving various medical requirements, assisting with replacement medications, transferring prescriptions and expanding our help line. Natural disasters or extreme weather events, such as wildfires, floods, hurricanes, tropical storms, and snow and ice storms, have impacted, and may in the future impact, our customers, associates, facilities and third-party vendors located in the affected area. Furthermore, climate change could result in certain types of natural disasters occurring more frequently or with more intense effects, which could have a long-term impact on general economic conditions and the health benefits and pharmacy services industries in particular.

LEGAL, REGULATORY AND PUBLIC POLICY RISKS

We are subject to significant government regulation, and changes or proposed changes in the regulation of our business by federal and state regulators may adversely affect our business, cash flows, financial condition and results of operations and the market price of our securities.

We are subject to significant state and federal regulation associated with many aspects of our business, including, but not limited to, licensing, premiums, marketing activities, provider contracting, access and payment standards, and corporate governance and financial reporting matters, as described in greater detail in Part I, Item 1, "Business - Regulation" in this Annual Report on Form 10-K. Further, the integration into our business of entities that we acquire, or our expansion into new businesses or jurisdictions, may increase our regulatory risk and affect the way in which existing laws and rules apply to us.

Frequent and sometimes unpredictable changes to existing laws, rules and regulations or judicial interpretation, application or enforcement thereof, or development of new laws, rules, regulatory interpretations or judgments could force us to change how we conduct our business, affect the products and services we offer (and where we offer them), restrict revenue and enrollment growth, increase our costs, including operating, healthcare technology and administrative costs, restrict our ability to obtain new product approvals and implement changes in premium rates, and require enhancements to our compliance infrastructure and internal controls environment, which could adversely impact our business and results of operations. In addition, legislative and/or regulatory policies or proposals that seek to manage the healthcare industry or otherwise impact our business may cause the market price of our securities to decrease, even if such policies or proposals never become effective. In particular, further regulations and modifications to the ACA and laws and regulations stemming from the ACA could impact the market for our products, funding for ACA programs, the regulations applicable to us and the fees and taxes payable by us and otherwise affect our business and future operations, some of which may adversely affect our financial condition and results of operations.

We are required to obtain and maintain insurance, licenses and other regulatory approvals to market certain of our products and services, to increase prices for certain regulated products and services and to consummate some of our acquisitions and dispositions.

Delays in obtaining or failure to obtain or maintain these approvals, as well as future regulatory action by state or federal authorities, could have a material adverse effect on the profitability or marketability of our health benefits, pharmacy services, healthcare and other products and services or on our business, financial condition, and results of operations. In addition, changes in government regulations, policies or funding that apply to government-sponsored programs such as Medicare and Medicaid including, among other things, reimbursement levels, quality-based bonus payment determinations, eligibility and redetermination requirements, benefit coverage requirements and additional governmental participation, have adversely affected, and could in the future adversely affect, our business, cash flows, financial condition, and results of operations. Although Medicaid eligibility redeterminations following COVID-19 suspensions slowed throughout 2024, CMS has provided that states have until December 31, 2025, to complete these eligibility redeterminations.

We have experienced past assessments under state or federal insolvency or guaranty association laws applicable to insurance companies, HMOs and other payers, and may experience assessments in the future if, for example, premiums established by other companies for their health insurance products, including certain long-term care products, are inadequate to cover their costs. Any such assessment could expose us to the risk of paying a portion of an impaired or insolvent insurance company's claims through state guaranty associations. We are not currently able to estimate our potential financial obligations, losses or the availability of offsets associated with potential guaranty association assessments; however, any significant increase in guaranty association assessments could have a material adverse effect on our business, cash flows, financial condition, and results of operations.

We expect state legislatures will continue to focus on healthcare delivery and financing issues, including actions to reduce or limit increases to premium payments, provider billing protections, access to care and other reforms of state health insurance markets. State ballot initiatives could also be put to voters that could materially impact our operating environment. If enacted into law, these state proposals and actions could have a material adverse impact on our business, cash flows, operations or financial condition. Additionally, state legislative actions and litigation could impact ERISA pre-emption. Further, in the past, Congress has considered, and may consider in the future, various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA, including limiting ERISA's preemptive effect on state laws, and other laws and could increase our costs, expose us to expanded liability, permit greater state regulation on our operations, or require us to revise the ways in which we conduct business.

We are subject to various risks associated with our international operations.

As we expand and operate our business outside of the U.S., we are presented with different challenges, including challenges in adapting to new markets, languages, business, labor and cultural practices, regulatory environments and local civil unrest or political controversy. Adapting to these challenges could require us to devote significant senior management attention and other resources. If we are unable to successfully manage our international operations, our business, cash flows, financial condition and results of operations could be adversely affected. In the future, we may acquire or operate new businesses outside of the U.S., increasing our exposure to these risks.

Certain of our subsidiaries operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business related to, among other things, local and cross border taxation, intellectual property, investment, currency rate differentials, management control, labor, anti-fraud, anti-corruption and privacy and data protection, which vary by jurisdiction. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or associates, restrictions or outright prohibitions on the conduct of our business and significant reputational harm and could adversely affect our ability to market our products and services, which may have a material adverse effect on our business, financial condition and results of operations.

We face risks related to litigation.

We are, and may in the future be, a party to a variety of private party and governmental legal actions and investigations that may affect our business, such as administrative charges before government agencies, employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims, intellectual property-related litigation and settlements. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, administration and offering of our products and services. These could include claims relating to the denial or limitation of health benefits; federal and state false claims act laws; dispensing of drugs associated with our pharmacy services business; professional liability claims arising out of the delivery of healthcare and related services to the public; development or application of medical policies and coverage and clinical guidelines; medical malpractice actions; allegations of anti-competitive and unfair business activities; provider disputes over reimbursement and contracts; provider tiering programs; narrow networks; termination of provider contracts; the recovery of overpayments from providers; fee-based business; disputes over co-payment calculations; reimbursement of out-of-network claims; the failure to disclose certain business practices; the failure to comply with various state or federal laws, including but not limited to: ERISA and the Mental Health Parity Act; the calculation of minimum

MLR and rebates related thereto; claims related to privacy, intellectual property and vendor disputes; claims related to our use of personal information and other proprietary data; and, customer audits and contract performance, including government contracts. These actions or proceedings could result in substantial costs to us, require management to spend substantial time focused on litigation, result in negative media attention, and may adversely affect our business, reputation, financial condition, results of operations and cash flows.

We are also involved in, or may in the future be party to, pending or threatened litigation incidental to the business we transact or arising out of our operations, including, but not limited to, breaches of security and violations of privacy requirements, shareholder actions, compliance with federal and state laws and regulations (including qui tam or "whistleblower" actions), or sales and acquisitions of businesses or assets. From time to time, we are involved as a party in various governmental inquiries, investigations, audits, reviews and administrative proceedings, including challenges relating to the award of government contracts. These investigations, audits and reviews include routine and special investigations by state insurance departments, various federal regulators including CMS and the HHS Office of Inspector General, state attorneys general, the Department of Justice, and various offices of the U.S. Attorney General. Following an investigation, we may be subject to civil or criminal fines, penalties, and other sanctions if we are determined to be in violation of applicable laws or regulations. Liabilities that may result from these actions could have a material adverse effect on our cash flows, results of operations and financial condition.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic (including injunctive relief), treble or punitive damages may be sought. Our international footprint also subjects us to additional potential disputes or differing interpretations related to contractual rights, tax positions, and regulatory oversight. Some liabilities and damages may not be covered by the insurance we carry, insurers may dispute coverage, or the amount of insurance may not be enough to cover the damages awarded. In addition, insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. Any adverse judgment against us resulting in such damage awards could result in negative publicity and have an adverse effect on our cash flows, results of operations and financial condition.

There are various risks associated with providing health benefits and other healthcare diversified products and services.

We continue to evolve our business to offer products and services beyond traditional health insurance, including digital health technology, pharmacy services, home health, and behavioral and clinical care services, which subjects us to litigation and regulatory risks that are different from our traditional product and services offerings and may materially affect our exposure to other risks.

The direct provision of healthcare services by certain of our subsidiaries involves risks of additional litigation brought against us or our associates for alleged malpractice or professional liability claims arising out of the delivery of healthcare and related services. In addition, liability may arise from maintaining healthcare premises that serve the public. Behavioral health services may also raise the risk profile of our business given the critical and sensitive nature of the services provided. In addition, we are, to a certain extent, self-insured with regard to litigation risks, including claims of medical malpractice against our affiliated physicians and us, and it is possible that the level of actual losses will significantly exceed the liabilities recorded for our estimates of the probable costs resulting from self-insured matters. The defense of any actions may result in significant expenses, and if we fail to maintain adequate insurance coverage for these liabilities, or if such insurance is not available, the resulting costs could adversely affect our business, cash flows, financial condition and results of operations. As we become more involved in direct care delivery and the provision of other services, such as crisis management services, there will be an increased possibility of litigation.

Additionally, many states in which certain of our subsidiaries operate limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals. Business corporations generally may not exercise control over the medical decisions of physicians, and we are not licensed to practice medicine. Rules and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary from state to state, and any enforcement actions by governmental officials alleging non-compliance with these rules and regulations could adversely affect our business, cash flows, financial condition and results of operations. Further, in certain states we are required to use professional corporations that are not affiliates, which exposes us to risk in the event the physician owners of those professional corporations take actions that are in breach of the contractual obligations that exist between us.

We rely on agreements with customers, confidentiality agreements with associates and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. Litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services, which could materially and adversely affect our results of operations, financial position and cash flows. Further, certain of our businesses use, develop or sell software products that may contain unexpected design defects or may encounter unexpected complications during integration or when used with other technologies utilized by the customer. A failure of these products to operate as intended and in a seamless fashion with other products could also materially and adversely affect our results of operations, financial position and cash flows.

Our pharmacy services business and pharmacy related operations are subject to risks and uncertainties that are in addition to those we face in our core healthcare business.

We provide pharmacy services and are responsible to regulators, our members and customers for the delivery of those pharmacy services that we contract to provide. Our pharmacy services business is subject to the risks inherent in the dispensing, packaging, fulfillment and distribution of pharmaceuticals and other healthcare products, including exposure to liabilities and reputational harm related to clinical quality, patient safety, infusion center operations, and other risks inherent in the dispensing, packaging and distribution of drugs, and other operational errors by us or our pharmacy services suppliers. Any failure by us or one of our pharmacy services suppliers to adhere to the laws and regulations applicable to the dispensing of pharmaceuticals could subject our pharmacy services business to civil and criminal penalties.

Our pharmacy services business is subject to federal and state laws and regulations that govern its relationships with pharmaceutical manufacturers, physicians, pharmacies and customers, including without limitation, federal and state anti-kickback laws, beneficiary inducement laws, consumer protection laws, ERISA, HIPAA and laws related to the operation of mail-service pharmacies, as well as an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy services business. In addition, the pharmacy services business, which conducts business through home delivery, infusion and specialty pharmacies, is subject to federal and state laws and regulations, including those of state boards of pharmacy, individual state-controlled substance authorities, the U.S. Drug Enforcement Agency and the U.S. Food and Drug Administration. Growth of our home delivery, specialty pharmacy and infusion services businesses subjects us to an increase in licensure requirements, and to regulatory and operational risks as our pharmacy services business becomes more vertically integrated. Also, we and our third-party vendors may be subject to certain registration requirements and state and federal laws related to the practice of pharmacy. Noncompliance with applicable laws and regulations by us or our third-party vendors could have material adverse effects on our business, results of operations, financial condition, liquidity and reputation.

Federal and state legislatures and regulators also regularly consider new laws and regulations and changes to existing regulations and policies for the industry that could materially affect current industry practices and our business. These new and changing laws and regulations include the regulation that was issued by HHS in November 2020 (but delayed to 2032 by the Inflation Reduction Act) related to drug manufacturer rebates, Medicaid spread pricing contract arrangements, the pricing of pharmaceuticals, the 2021 Appropriations Act provisions on drug price reporting and potential new regulations or legislation regarding commercial spread pricing, rebates, fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, pharmacy benefit manager compensation, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks, prohibitions on pharmacy steering and pharmacy network reimbursement methodologies, and reporting requirements, as well as greater state regulation of pharmacy benefit managers and state involvement in the self-insured and Medicare Part D markets, which are typically preempted by federal law. Further, various government agencies have conducted and continue to conduct investigations and studies into certain pharmacy services practices, which have resulted and may in the future result in pharmacy benefit managers agreeing to civil penalties, including the payment of money and entry into corporate integrity agreements, or could materially and adversely impact the pharmacy services business model. These changes in legislation within the prescription drug industry and pharmacy benefit management practices have both short-term and long-term impacts that could have a material adverse effect on our business and results of operations.

We are a party to license agreements with the BCBSA that entitle us to the exclusive and, in certain areas, non-exclusive use of the BCBS names and marks in our geographic territories. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, cash flows, financial condition and results of operations.

Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the BCBS names and marks, and failure to comply with those requirements could result in a termination of the license agreements. The license agreements may be modified by the BCBSA, which could have a material adverse effect on our future expansion plans or results of operations. Further, BCBS licensees have certain requirements to perform administrative services for members of other BCBS licensees. As of December 31, 2024, we provided health benefit and other healthcare services to approximately 34 million Blue Cross and/or Blue Shield enrollees. If we or another BCBS licensee are not in compliance with all legal requirements or are unable to perform administrative services as required, this could have an adverse effect on our members and our ability to maintain our licenses, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the BCBS names and marks or to sell BCBS health insurance products and services in one or more of our service areas. Furthermore, the BCBSA would be free to issue a license to use the BCBS names and marks in these service areas to another entity. Our existing BCBS members would be provided with instructions for obtaining alternative products and services licensed by the BCBSA. We believe that the BCBS names and marks are valuable identifiers of our products and services in the marketplace.

Upon termination of either license agreement, the BCBSA would have the right to impose a "Re-establishment Fee" upon us, which would be used in part to fund the establishment of a replacement Blue Cross and/or Blue Shield licensee in the vacated service area. The fee is set at $98.33 per licensed enrollee. If the Re-establishment Fee were applied to our total Blue Cross and/or Blue Shield enrollees of approximately 34 million as of December 31, 2024, we would be assessed approximately $3 billion by the BCBSA. As a result, termination of the license agreements would have a material adverse effect on our business, cash flows, financial condition and results of operations. For more information on the BCBSA license agreements, including requirements, restrictions and termination events set forth in these license agreements, see Part I, Item 1, "Business - BCBSA Licenses" of this Annual Report on Form 10-K.

Indiana law, other applicable laws, our articles of incorporation and bylaws, and provisions of our BCBSA license agreements may prevent or discourage takeovers and business combinations that our shareholders might consider to be in their best interest.

Indiana law, other applicable laws and regulations and provisions in our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context or adversely affect the price that some investors are willing to pay for our stock.

The insurance holding company system acts and certain health statutes of the states in which our insurance company or HMO subsidiaries are regulated restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Further, the Indiana Business Corporation Law contains business combination provisions that, in general, prohibit for five years any business combination with a beneficial owner of 10% or more of our common stock unless the holder's acquisition of the stock was approved in advance by our Board of Directors.

Our articles of incorporation and bylaws contain provisions that could have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider to be in their best interests. Our articles of incorporation provide that no person may beneficially own shares of voting capital stock beyond specified ownership limits, except with the prior approval of a majority of the "continuing directors." The ownership limits, which may not be exceeded without the prior approval of the BCBSA, are the following: (1) for any institutional investor (as defined in our articles of incorporation), one share less than 10% of our outstanding voting securities; (2) for any non-institutional investor (as defined in our articles of incorporation), one share less than 5% of our outstanding voting securities; and (3) for any person, one share less than the number of shares of our common stock or other equity securities (or a combination thereof) representing a 20% ownership interest in us.

In addition, our articles of incorporation and bylaws: divide our Board of Directors into three classes serving staggered three-year terms (which is required by our license agreements with the BCBSA); permit our Board of Directors to determine the terms of and issue one or more series of preferred stock without further action by shareholders; restrict the maximum number of directors and the ability to increase that number; limit the ability of shareholders to remove directors; impose restrictions on shareholders' ability to fill vacancies on our Board of Directors; impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; prohibit shareholders from amending certain provisions of our bylaws; and impose restrictions on who may call a special meeting of shareholders.

The health benefits industry is subject to negative publicity, which could adversely affect our business, cash flows, financial condition and results of operations.

Negative publicity in the healthcare industry is driven by factors that include, but are not limited to, premium rate increases, prior authorization practices, industry consolidation, cost of care initiatives and debate about current or proposed legislation. Such publicity may lead to more regulation and legislative review of industry practices, which may increase business costs and impact profitability by constraining our ability to market, maintain or expand our product and service offerings and result in increased regulatory oversight of our operations. Negative publicity and perception of the health benefits industry in general, the BCBSA, other BCBSA licensees, us, or our key vendors could limit our ability to attract and retain talent, impact the security of our workforce, and adversely affect our business, cash flows, financial condition and results of operations.

STRATEGIC RISKS

We face competition in many of our markets, and if we fail to adequately adapt to changes in our industry and develop and implement strategic growth opportunities, our ability to compete and grow may be adversely affected.

As a health company offering health benefits, pharmacy services and other diversified products and services, we operate in a highly competitive industry that is subject to significant changes from and competition due to legislative reform, business consolidations, new strategic alliances, new market entrants, aggressive marketing practices, technological advancements and changing market practices such as increasing usage of telehealth. We also must respond to pricing and other actions taken by existing competitors, suppliers and potentially disruptive new entrants in the Public Exchanges and in our other lines of business. These factors have produced and will continue to produce significant pressures on our profitability and membership. Furthermore,

decisions to buy our products and services are increasingly made or influenced by consumers, through means such as direct purchasing (for example, Medicare Advantage plans) and insurance exchanges that allow individual choice, or by large employers that may increasingly be able to contract directly with providers. Our success and future growth depend on our ability to compete effectively under these unique market pressures in the consumer-driven marketplace, and our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands.

In addition, the pharmacy services industry is highly competitive, and our pharmacy services business unit is subject to competition from national, regional and local pharmacy services providers, other insurers, health plans, large retail pharmacy chains, large retail stores, supermarkets, mail order and web pharmacies, discount cards and specialty pharmacies. Strong competition within the pharmacy services business has generated greater demand for lower product and service pricing and enhanced product and service offerings. Our inability to maintain positive trends, or to contract on favorable terms with CVS, wholesalers or pharmaceutical manufacturers for, among other things, rebates, discounts, administrative fees and inventory purchase prices, or a failure to identify and implement new ways to mitigate pricing pressures, could negatively impact our ability to attract or retain customers, negatively impact our margins and have a material adverse effect on our business and results of operations. In addition, legislative reforms such as the regulation issued by HHS related to rebates and the 2021 Appropriations Act, which requires reporting of plan spending, the cost of plan pharmacy benefits, enrollee premiums and any manufacturer rebates received by the plan or issuer, may adversely affect our competitive position, cash flows, financial condition and results of operations.

In order to achieve our long-term financial targets, we need to not only grow our profitable medical membership, but also continue to profitably grow and diversify our sources of revenue and earnings, including through the increased sale of our pharmacy services, both integrated and external, other healthcare services and products, and specialty products, such as stop loss, dental, vision and other supplemental products, expand our products and services and establish new cost of care solutions. If we are unable to execute our strategy with respect to the growth of our healthcare, pharmacy services, and other diversified products and services businesses, or if we are unable to acquire or develop and successfully manage new opportunities that further our strategic objectives and differentiate our products and services from our competitors, our ability to profitably grow our business could be adversely affected.

We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our healthcare products, particularly with respect to individuals, seniors and certain group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address legislative changes, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure that we will be able to compete successfully against current and future competitors for these services or that competitive pressures faced by us will not materially and adversely affect our business, cash flows, financial condition and results of operations.

For additional information, see “Business - Competition” in Part I, Item 1 of this Annual Report on Form 10-K.

We have built a significant portion of our current business through mergers and acquisitions, joint ventures, strategic alliances and investments, and although we expect to pursue such opportunities in the future, we are subject to risks resulting from such business combinations.

The following are some of the risks associated with mergers, acquisitions, divestitures, joint ventures and strategic alliances and investments, referred to collectively as business combinations, that could have a material adverse effect on our business, cash flows, financial condition and results of operations:

- some business combinations may not achieve anticipated revenues, earnings or cash flow, business opportunities, synergies, growth prospects or other anticipated benefits;
- we may assume liabilities that were not disclosed to us, or which were underestimated, and which could lead to legal challenges, investigations and enforcement actions, and we may not be able to adequately recover from sellers or insurance carriers for such assumed liabilities;
- we may experience difficulties in integrating business combinations, including into our internal control environment and culture, be unable to integrate business combinations successfully or as quickly as expected and be unable to realize anticipated economic, operational and other benefits in a timely manner or at all;
- business combinations and proposed business combinations that are not completed could disrupt our ongoing business, lead to the incurrence of significant fees, distract management, result in the loss of key associates, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies and procedures;
- IT system vulnerabilities may be more acute for IT systems associated with recently acquired businesses, and we may be unable to address such vulnerabilities, inadequacies, or failures immediately after acquiring a business, which could undermine integration activities, delay launch of acquired products, and increase infrastructure risk;

- we may finance future business combinations by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- we may compete with other firms, some of which may have greater financial and other resources, to acquire attractive companies;
- we may experience disputes with or competition from our partners or former partners in our strategic alliances, investments and joint ventures, which could result in litigation or a loss of business;
- we may not be able to obtain required regulatory approval for an acquisition, in a timely manner, or at all, and government actions such as actions by the Federal Trade Commission, Department of Justice, or state governmental agencies, may affect our ability to complete our business combinations, which could result in additional expenditures required to develop products and services internally, place us at a competitive disadvantage, or impact market perceptions of our business and brand;
- the integration of entities we acquire into our business may affect the way in which existing and future laws and rules apply to us, including expansion of applicability; and
- future business combinations may make it difficult to comply with the requirements of the BCBSA and lead to a risk that our BCBSA license agreements may be terminated.

We face intense competition to attract and retain associates. Further, managing key executive succession and retention is critical to our success.

Our success depends on our ability to attract, develop and retain qualified associates, including those with diverse backgrounds, experience and skill sets, to operate and expand our business. We face intense competition for experienced and highly skilled associates, and we may be unable to attract and retain such associates, or competition among potential associates may result in increasing salaries. Further, adverse changes to our corporate culture could harm our business operations and our ability to retain key associates and executives. An inability to retain and attract associates and executives could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition, if we are unable to attract, retain and effectively manage the succession plans for key associates and executives, including our President and Chief Executive Officer, our business, results of operations and future performance could be adversely affected. We may have difficulty in replacing key executives because of the limited number of qualified individuals with the breadth of skills and experience required to operate and successfully expand our business. The succession plans we have in place for members of our senior management and employment arrangements with certain key executives do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract, transition and retain suitable successors.

Restrictions on our ability to obtain funds from our regulated subsidiaries could limit our ability to repurchase shares, pay dividends and meet our obligations and materially adversely affect our business, cash flows, financial condition and results of operations.

As a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries. Among other restrictions, state insurance and HMO laws restrict the ability of most of our regulated subsidiaries to pay dividends. In some states, we have made special undertakings that may further limit the ability of our regulated subsidiaries to pay dividends. Our ability to repurchase shares, pay dividends to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, cash flows, financial condition and results of operations.

In addition, most of our regulated subsidiaries are subject to minimum capital requirements and periodic financial reporting that require them to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain these minimum standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. We are also a party to license agreements with the BCBSA which contain additional minimum capital and liquidity requirements. Changes to existing minimum capital requirements could further restrict the ability of our regulated subsidiaries to pay dividends and adversely affect our business.

Our regulated subsidiaries are subject to state laws and regulations that require diversification of their investment portfolios and limit the amount of investments in certain investment categories. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and in some instances, require the sale of those investments.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future, which could adversely affect our ability to pursue desirable business opportunities and to react to changes in the economy or our industry.

Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. We are exposed to interest rate risk to the extent of our variable rate indebtedness. Increases in interest rates could increase our cost of borrowing, and volatility in U.S. and global financial markets could impact our access to, or further increase the cost of, financing. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate to meet scheduled debt service obligations or may not be available on commercially reasonable terms.

We may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit facilities or other indebtedness. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement or our other indebtedness is accelerated, we may be unable to repay or finance the amounts due, on commercially reasonable terms, or at all.

A downgrade in our credit ratings could have an adverse effect on our business, cash flows, financial condition and results of operations.

Claims-paying ability, financial strength and debt ratings by nationally recognized statistical rating organizations are important factors in establishing the competitive position of insurance and health benefits companies. We believe our strong credit ratings are an important factor in marketing our products to customers. In addition, if our credit ratings are downgraded or placed under review, our business, cash flows, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs. Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future.

The value of our intangible assets may become impaired.

As of December 31, 2024, we had $40.4 billion of goodwill and other intangible assets, representing 34.5% of our total consolidated assets. In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets for potential impairment, using assumptions and judgments regarding the estimated fair value of our reporting units. Estimated fair values might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

The value we place on intangible assets may be adversely impacted if existing or future business combinations fail to perform in a manner consistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Further, the estimated value of our reporting units may be impacted because of business decisions we make associated with any future changes to laws and regulations, which could unfavorably affect the carrying value of certain goodwill and other intangible assets and result in impairment charges in future periods. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity which could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

We maintain a significant investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks. As a result, we may experience a reduction in value or loss of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition. Changes in the economic environment, including periods of increased volatility in the securities markets, recent changes in interest rates and currency exchange rates, can increase the difficulty of assessing investment impairment and increase the risk of potential impairment of these assets. There is continuing risk that declines in the fair value of our investments may occur and material impairments may be charged to income in future periods, resulting in recognized losses.

GENERAL RISKS

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

- adverse securities and credit market conditions, which could impact our ability to meet liquidity needs;

- any requirement to restate financial results in the event of inappropriate application of accounting principles;
- changes in tax laws and regulations, uncertainty in the interpretation of tax laws and regulations or unfavorable resolutions of exams that could impact the future value of our deferred tax assets and deferred tax liabilities, or result in significant one-time charges in the current or future taxable years;
- a significant failure of our internal control over financial reporting;
- provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers; and
- failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED STAFF COMMENTS.

None.

ITEM 1C. CYBERSECURITY

We operate in a highly regulated industry. Federal, state and international laws and contractual commitments guide our collection, use and disclosure of confidential information such as protected health information, personal financial information and personally identifiable information. Our success depends on maintaining a high level of trust among our stakeholders, including our consumers, clients, business partners, providers, regulators and associates. Failure to effectively secure, maintain and upgrade our information systems, or the availability and integrity of our data, could adversely affect our business, including our business strategy, cash flows, financial condition and results of operations.

Cybersecurity Risk Assessment

Our cybersecurity and risk management programs are part of our continuously evolving enterprise-wide risk management practices. Aligned and measured against the National Institute of Standards and Technology (NIST) Cybersecurity Framework, recognized best practices and standards for cybersecurity and information technology, industry and government standards and other guidelines, our cybersecurity and risk management programs utilize policies, processes, and technologies to identify, assess, manage and mitigate cybersecurity risks and threats we face. We also conduct periodic reviews and updates to uphold our security standards, including implementation of tabletop crises exercises. Our management implements ongoing and annual risk assessment processes to identify and manage risks that could affect our ability to safeguard sensitive data or provide reliable transaction processing and to minimize financial risk exposure. These risks include, but are not limited to, regulatory compliance; third-party management, including risks from business partners and software providers; mergers and acquisitions; system availability and disruption of business operations; data use and security; vulnerability and configuration management; fraud and extortion; and reputation risk.

The steps we take to reduce vulnerability to cyber-attacks and to mitigate and remediate the impact of cybersecurity incidents in a timely and coordinated manner include, but are not limited to: establishing information security policies and standards, implementing information protection processes, tools and technologies, monitoring information technology systems for cybersecurity threats, coordinating internal reporting, assessing cybersecurity risk profiles of key third-parties, implementing cybersecurity training and collaborating with public and private organizations on cyber threat information and best practices.

In addition to our internal Information Security teams, we also utilize trusted third-party auditors and recognized cybersecurity consultants and certified assessors, to assess cybersecurity risks, related controls, and alignment to relevant regulatory and legal requirements. A third party evaluates our information security policies, standards and control environment at least annually. Assessments and testing protocols are performed against industry best practices and widely recognized security frameworks.

We face many cybersecurity risks in connection with our business. As of December 31, 2024, no known cybersecurity threats have materially affected, or are reasonably likely to materially affect, the Company, including our business strategy, cash flows, financial condition or results of operations; however, future cybersecurity incidents or threats may materially affect us, including by affecting our business strategy, results of operations or financial conditions. See Part I, Item 1A. “Risk Factors” for more information on the Company’s cybersecurity-related risks.

Management and Governance of Cybersecurity Risk

To manage our cybersecurity risk, we employ a cross-organizational steering committee, the Information Security Steering Committee ("ISSC"), that supports the direction and governance of our enterprise-wide Information Security Program. The ISSC is chaired by our Chief Information Security Officer ("CISO") and is comprised of accountable senior business leaders including our Chief Compliance Officer ("CCO"), Chief Risk Officer ("CRO"), legal counsel, and human resources, procurement and business segment leaders.

In addition to the ISSC, we have defined risk functions to cover overall enterprise risks and information technology and cybersecurity risks within our enterprise risk management framework, including, but not limited to: our IT Risk Management program, led by our CISO; our Responsible Artificial Intelligence ("RAI") Program, led by our Chief Digital Information Officer; Compliance, led by our CCO; Internal Audit, led by our Chief Audit Executive ("CAE"); Enterprise Risk Management programs led by our CRO; Third-Party Risk Management, comprised of business and information security leaders; IT due diligence processes, led by business, technology and information security leaders; and our Corporate Insurance Program, including cybersecurity insurance, led by our Treasurer.

To evaluate cybersecurity and privacy incidents and enable us to comply with public disclosure requirements, we have a Privacy and Security Incident Response and Reporting Policy and Procedure (the "Policy") with defined escalation criteria (the "Plan") in support of our incident response processes. The Plan provides a framework to our Cyber Incident Response Taskforce, comprised of our Chief Privacy Officer ("CPO"), CISO and applicable legal counsel and business and corporate services leaders, for responding to cybersecurity incidents. The Policy, together with the Plan, identifies applicable requirements for incident disclosure and reporting and also provides protocols for incident evaluation based on facts and circumstances of each incident, including the use of third-party service providers and partners, processes for notification and internal escalation of information to our senior management, including to our chief legal officer and CEO, a subcommittee of our SEC disclosure committee, and ultimately, our Board of Directors and appropriate Board committees. The Policy also addresses requirements for our external reporting obligations. The Policy is reviewed and updated, as necessary, under the leadership of our CISO and CPO.

Our Board oversees and guides our business and oversees our exposure to major risks, including steps taken by management to monitor and mitigate cybersecurity risks. The Board receives and reviews periodic reports from management on various risks, and delegates to its Audit Committee certain oversight responsibilities. The Board monitors cybersecurity risks and receives a report at least quarterly from our CISO regarding our Information Security Program. In addition, certain cybersecurity incidents are escalated to the Board in accordance with our Plan as described above. Periodically, the Board also receives third party assessments of our information security. The Audit Committee receives regular updates on both information security and data privacy matters, and oversees data privacy, integrity, incident and breach risks.

Cybersecurity Expertise

Our Information Security Program has been established with the mission of minimizing risk to our member, client and associate data and it is managed by our CISO. Our current CISO has over 30 years of experience in information security and technology and has held a wide variety of technical and strategic leadership positions. He holds advanced certifications including Certified Information Systems Security Professional and Certified Secure Software Lifecycle Professional.

Our associates, including those responsible for cybersecurity, are evaluated for competence, including the knowledge and skills necessary to accomplish tasks that define associates' roles and responsibilities and undergo regular training regarding security-awareness, privacy, ethics and compliance. Our job summaries contain specific educational and knowledge requirements necessary for cybersecurity jobs. In addition, a criminal background check is completed for all new associates and performance reviews are conducted annually to measure performance results and achievements and to assess the job competency of our associates.

ITEM 2. PROPERTIES.

We lease our principal executive offices located at 220 Virginia Avenue, Indianapolis, Indiana. In addition to this location, we have operating facilities located in each state where we operate as licensees of the BCBSA and in other states or countries where we operate under our other brands. A majority of these locations are also leased properties. Our facilities

support our various business segments. We operate in a hybrid workforce environment and believe that our properties are adequate and suitable for our business as presently conducted.

ITEM 3. LEGAL PROCEEDINGS.

For information regarding our legal proceedings, see Note 14, "Commitments and Contingencies – *Litigation and Regulatory Proceedings*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, which information is incorporated herein by reference.

ITEM 4. MINE SAFETY DISCLOSURES.

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

Market Information

Our common stock, par value $0.01 per share, is listed on the NYSE under the symbol "ELV."

Holders

As of February 1, 2025, there were 46,307 shareholders of record of our common stock.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under our equity compensation plans is set forth in Part III, Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in this Annual Report on Form 10-K.

Issuer Purchases of Equity Securities

The following table presents information related to our repurchases of common stock for the periods indicated (*in millions, except share and per share data*):

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs[2]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
October 1, 2024 to October 31, 2024	801,484	421.93	798,055	$ 10,774
November 1, 2024 to November 30, 2024	1,859,856	409.95	1,856,962	10,013
December 1, 2024 to December 31, 2024	1,858,281	383.93	1,857,988	9,300
	4,519,621		4,513,005	

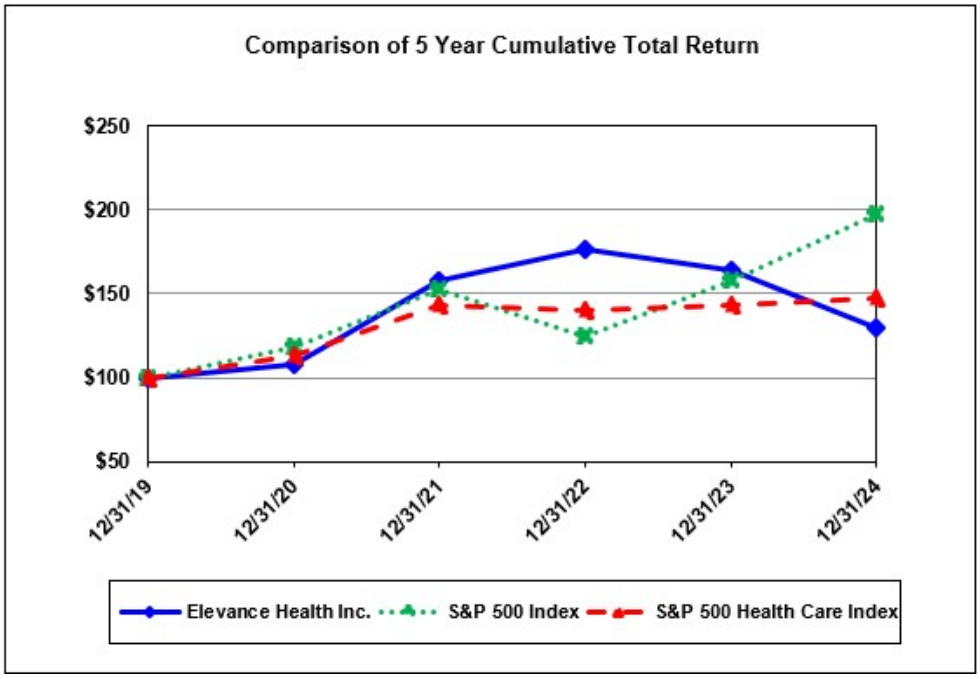
1 Total number of shares purchased includes 6,616 shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.

2 Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board evaluates periodically. During the year ended December 31, 2024, we repurchased 6,661,737 shares at an aggregate cost of $2,900 under the program, including the cost of options to purchase shares. The Board of Directors has authorized our common stock repurchase program since 2003. The most recent authorized increase to the program was $8,000 on October 15, 2024 by our Audit Committee, pursuant to authorization granted by the Board of Directors. No duration has been placed on our common stock repurchase program, and we reserve the right to discontinue the program at any time.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from December 31, 2019 through December 31, 2024, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard and Poor's 500 Health Care Index (the "S&P 500 Health Care Index"). The graph assumes an investment of $100 on December 31, 2019 in each of our common stock and these indices (and the reinvestment of all dividends).

The comparisons shown in the graph below are based on historical data, and we caution that the stock price performance shown in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our common stock. Information used in the graph was obtained from S&P Global Market Intelligence, a source believed to be reliable, but we are not responsible for any errors or omissions in such information. The following graph and related information shall not be deemed "soliciting materials" or to be "filed" with the SEC, nor shall such information be incorporated by reference into any future filing under the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.



	December 31,					
	2019	2020	2021	2022	2023	2024
Elevance Health, Inc.	$ 100	$ 108	$ 157	$ 176	$ 164	$ 130
S&P 500 Index	100	118	152	125	158	197
S&P 500 Health Care Index	100	113	143	140	143	147

Based upon an initial investment of $100 on December 31, 2019 with dividends reinvested.

ITEM 6. [RESERVED]

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

(In Millions, Except Per Share Data or as Otherwise Stated Herein)

This Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") should be read in conjunction with the accompanying audited consolidated financial statements and notes, included in Part II, Item 8 of this Annual Report on Form 10-K. References to the terms "we," "our," "us," "Elevance Health" or the "Company" used throughout this MD&A refer to Elevance Health, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia and Puerto Rico, unless the context otherwise requires.

This MD&A generally discusses 2024 and 2023 items and year-over-year comparisons between 2024 and 2023. A detailed discussion of 2022 items and year-over-year comparisons between 2023 and 2022 that are not included in this Annual Report on Form 10-K can be found in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 included in our Annual Report on Form 10-K for the year ended December 31, 2023.

Overview

Elevance Health is a health company with the purpose of improving the health of humanity. We are one of the largest health insurers in the United States in terms of medical membership, serving approximately 45.7 million medical members through our affiliated health plans as of December 31, 2024. We are an independent licensee of the Blue Cross and Blue Shield Association ("BCBSA"), an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield ("BCBS") licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross and Anthem Blue Cross and Blue Shield. We also conduct business through arrangements with other BCBS licensees, as well as other strategic partners. In addition, we serve members in numerous states as Wellpoint, Carelon, MMM and/or Simply Healthcare. We are licensed to conduct insurance operations in all 50 states, the District of Columbia and Puerto Rico through our subsidiaries. Through various subsidiaries, we also offer pharmacy services through our CarelonRx business, and other healthcare related services as Carelon Insights and Carelon Health.

We have organized our brand portfolio into the following core go-to-market brands:

- Anthem Blue Cross/Anthem Blue Cross and Blue Shield — represents our Anthem-branded and affiliated Blue Cross and/or Blue Shield licensed plans;
- Wellpoint — unites select non-BCBSA licensed Medicare, Medicaid and commercial plans under the Wellpoint name; and
- Carelon — this brand brings together our healthcare related services and capabilities, including our CarelonRx and Carelon Services businesses, under a single brand name.

We report our results of operations in the following four reportable segments: Health Benefits, CarelonRx, Carelon Services and Corporate & Other (our businesses that do not individually meet the quantitative thresholds for an operating segment, as well as corporate expenses not allocated to our other reportable segments).

Our results of operations discussed throughout this MD&A are determined in accordance with generally accepted accounting principles ("GAAP"). We also calculate operating gain and operating margin to further aid investors in understanding and analyzing our core operating results. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and operating expense. Operating margin is calculated as operating gain divided by operating revenue. Our definition of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating periods and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or fully-diluted shareholders' earnings per share ("EPS") prepared in accordance with GAAP. For additional details on operating gain, see our "Reportable Segments Results

of Operations" discussion included in this MD&A. For a reconciliation of reportable segment operating revenue to the amounts of total revenue included in the consolidated statements of income and a reconciliation of reportable segment operating gain to income before income tax expense, see Note 20, "Segment Information," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Our operating revenue consists of premiums, product revenue, and service fees. Premium revenue is generated from risk-based contracts where we indemnify our policyholders against costs for covered health benefits. Product revenue represents services performed by CarelonRx for unaffiliated pharmacy customers and includes ingredient costs (net of any rebates or discounts), including co-payments made by or on behalf of the customer, and service fees. Unaffiliated pharmacy customers include our fee-based employer groups that contract with CarelonRx for pharmacy services and external customers outside of the health plans we own. Service fees are generated from our fee-based customers for the processing of transactions or network discount savings realized, revenues from our Medicare processing business and revenues from other health-related businesses, including care management programs and miscellaneous other income.

Our benefit expense primarily includes costs of care for health services consumed by our risk-based members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug prices. Utilization rates represent the volume of consumption of health services and prescription drugs, and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by us. Any changes in these estimates are recorded in the period the need for such an adjustment arises. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. Our managed care plans include: Preferred Provider Organizations; Health Maintenance Organizations; Point-of-Service plans; Traditional Indemnity plans and other hybrid plans, including Consumer-Driven Health Plans; and hospital only and limited benefit products.

We classify certain quality improvement costs as benefit expense. Quality improvement activities are those designed to improve member health outcomes, prevent hospital readmissions and improve patient safety. They also include expenses for wellness and health promotion provided to our members. These quality improvement costs may be comprised of expenses incurred for: (i) medical management, including care coordination and case management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies, congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy, such as identification and use of best clinical practices to avoid harm, identifying clinical errors and safety concerns, and identifying potential adverse drug interactions.

Our cost of products sold represents the cost of pharmaceuticals dispensed by CarelonRx for our unaffiliated pharmacy customers (net of rebates or discounts), including any co-payments made by or on behalf of the customer, per-claim administrative fees for prescription fulfillment and certain direct costs related to sales and administration of customer contracts.

Our operating expenses consist of fixed and variable costs. Examples of fixed costs are depreciation, amortization and certain facilities expenses. Certain variable costs, such as premium taxes, vary directly with premium volume. Commission expense generally varies with premium or membership volume. Other variable costs, such as salaries and benefits, do not vary directly with changes in premium but are more aligned with changes in membership or services provided to our customers. The acquisition or loss of a significant block of business would likely impact staffing levels and thus, associated compensation expense. Other variable costs include professional and consulting expenses and advertising. Other factors can impact our administrative cost structure, including systems efficiencies, inflation and changes in productivity.

Our results of operations depend in large part on our ability to accurately predict and effectively manage healthcare costs through effective contracting with providers of care to our members, product pricing, medical management and health and wellness programs, including service coordination and case management for addressing complex and specialized healthcare needs, innovative product design and our ability to maintain or achieve improvement in our Centers for Medicare and Medicaid Services Star Ratings. Several economic factors related to healthcare costs, such as regulatory mandates of

coverage as well as direct-to-consumer advertising by providers and pharmaceutical companies, have a direct impact on the volume of care consumed by our members. The potential effect of escalating healthcare costs, any changes in our ability to negotiate competitive rates with our providers and any regulatory or market-driven restrictions on our ability to obtain adequate premium rates to offset overall inflation in healthcare costs, including increases in unit costs and utilization rates resulting from the aging of the population and other demographics, the impact of epidemics and pandemics, as well as advances in medical technology and pharmaceuticals, may impose further risks to our ability to profitably underwrite our business and may have a material adverse impact on our results of operations.

We intend to expand through a combination of organic growth, strategic acquisitions and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale, as well as provide us access to new and evolving technologies and products. In addition, we believe geographic and product diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. We market and offer pharmacy services through CarelonRx and other subsidiaries, and we expect CarelonRx to continue to improve our ability to integrate pharmacy benefits within our medical and specialty platform. We have continued growing our government-sponsored business through organic growth and acquisitions. In all other markets, we intend to maintain our position by delivering excellent service, offering competitively priced products, providing access to high-quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Cross and Blue Shield names and marks.

For additional information about our business and reportable segments, see Part I, Item 1 “Business” and Note 20, “Segment Information” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Business Trends

We continue to participate in the Individual state- or federally-facilitated marketplaces (“the Public Exchange”) in nearly all of our Anthem Blue Cross and Anthem Blue Cross and Blue Shield service areas. We anticipate growth in our Public Exchange memberships as former Medicaid members, no longer eligible for Medicaid coverage, continue to seek alternative coverage options. Additionally, we are entering select service areas in Florida, Maryland, and Texas in 2025, using our Simply Healthcare and Wellpoint brands, and we are actively evaluating expansion opportunities in additional marketplaces beyond 2025. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact significant modifications to existing laws and regulations, including changes to available subsidies, taxes and fees.

CarelonRx markets and offers pharmacy services to our affiliated health plan customers throughout the country, as well as to customers outside of the health plans we own. Our comprehensive pharmacy services portfolio includes all core pharmacy services, such as home delivery and specialty pharmacies, claims adjudication, formulary management, pharmacy networks, rebate administration, a prescription drug database and member services, as well as infusion services and injectable therapies.

CarelonRx delegates certain core pharmacy services to CaremarkPCS Health, L.L.C., which is a subsidiary of CVS Health Corporation (“CVS”), pursuant to an agreement (the “CVS Agreement”) with the current contractual term extending through December 31, 2027. We can elect to have CVS continue to provide services to us for a three-year extension period on the same terms and conditions as in the current CVS Agreement in the event of a termination or non-renewal by either party.

Pricing Trends: We strive to price our health benefit products consistent with anticipated underlying medical cost trends. We frequently make adjustments to respond to legislative and regulatory changes as well as pricing and other actions taken by existing competitors and new market entrants. Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. Product pricing remains competitive.

If the approvals of any annual premium rate changes by contracted government agencies are delayed, we are required to defer the recognition of any premium rate increases to the period in which the premium rates become final. The impact of this deferral can be significant in the period in which the increased premium rates are first recognized depending on the magnitude of the premium rate increase, the number of members to which it applies and the length of the delay between the

effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period in which the contract amendment affecting the rate is finalized.

Medical Cost Trends: Our medical cost trends are primarily driven by changes in the utilization of services across all provider types and the unit cost of these services. We work to mitigate these trends through various medical management programs such as care and condition management, program integrity and specialty pharmacy management and utilization management, as well as benefit design changes. There are many drivers of medical cost trends that can cause variance from our estimates, such as changes in the level and mix of services utilized, regulatory changes, aging of the population, health status and other demographic characteristics of our members, epidemics, pandemics, advances in medical technology, new high-cost prescription drugs, new indications of existing prescription drugs, provider contracting inflation, labor costs and healthcare provider or member fraud.

For additional discussion regarding business trends, see Part I, Item 1 “Business” of this Annual Report on Form 10-K.

Regulatory Trends and Uncertainties

The Consolidated Appropriations Act of 2023, decoupled Medicaid eligibility redeterminations from the COVID-19 Public Health Emergency initially declared in January 2020. As a result, states were permitted to begin removing ineligible beneficiaries from their Medicaid programs starting April 1, 2023, and the majority of our Medicaid markets began doing so as of June 30, 2023. Although most states have completed this process, Centers for Medicare and Medicaid Services (“CMS”) has provided that states have until December 31, 2025 to complete these eligibility redeterminations. Since redeterminations have resumed, we have continued to experience a decline in our Medicaid membership. We expect growth over time in our commercial plans, including through the Public Exchanges in states where we offer commercial plans, as members who have lost Medicaid coverage seek alternative coverage elsewhere.

The Inflation Reduction Act of 2022 contains a variety of provisions that have impacted, and continue to impact our business including by extending the American Rescue Plan Act of 2021's enhanced Premium Tax Credits (“PTC”) through 2025; imposing a new corporate alternative minimum tax; providing a one percent excise tax on repurchases of stock; allowing CMS to negotiate prices on a limited set of prescription drugs in Medicare effective in 2026; instituting caps on insulin cost sharing in Medicare; redesigning the Medicare Part D benefit; requiring drug manufacturers to pay rebates if prices increase beyond inflation; and delaying the implementation of the Trump Administration Medicare drug rebate rule until at least 2032. The extension of the enhanced PTC has allowed for growth in Individual Public Exchange enrollment and has supported continuity of coverage since Medicaid eligibility redeterminations resumed in 2023. If Congress does not act to extend the enhanced PTC, they will expire at the end of 2025, which could have a material adverse effect on our business and results of operations.

The Consolidated Appropriations Act of 2021 (the “2021 Appropriations Act”) has impacted our business, including by imposing additional disclosure and reporting requirements related to broker compensation, mental health parity, pharmacy benefits and drug costs, as well as procedures and coverage requirements related to surprise medical bills, provider directory maintenance and continuity of care for certain patients. The requirements applicable to us under the 2021 Appropriations Act had varying effective dates, beginning in December 2021.

The health plan price transparency regulations issued by the U.S. Departments of Health and Human Services, Labor, and Treasury (“the Tri-Agencies”) pursuant to the 2021 Appropriations Act required us to begin disclosing certain pricing information regarding negotiated rates and historical payment information with providers in 2022. Additionally, as directed by law, we make available to members personalized out-of-pocket cost information and underlying negotiated rates.

In September 2024, the Tri-Agencies issued final regulations related to mental health parity that will require health plans to make administrative and operational changes to comply with these final regulations. While some provisions became effective on January 1, 2025, additional guidance from the Tri-Agencies will be necessary to assess the full impact of these regulations on our operations and financial results. Litigation has been filed challenging the final regulation and is pending court action.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively, the “ACA”), continues to impact our business and results of operations, including pricing, minimum

medical loss ratios, and the geographies in which our products are available. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, including evolving methodology for ratings and quality bonus payments. CMS also frequently proposes changes to its program that audits data submitted under the risk adjustment programs in ways that could increase financial recoveries from plans.

For additional discussion regarding regulatory trends and uncertainties, and risk factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K, see Part I, Item 1 "Business-*Regulation*" and Part I, Item 1A "Risk Factors."

Other Significant Items

Business and Operational Matters

During the third quarter of 2023, based on a strategic review of our operations, assets and investments, management implemented the "2023-2024 Business Efficiency Program" to refine the focus of our investments, and optimize our physical footprint. The 2023-2024 Business Efficiency Program included the write-off of certain information technology assets and contract exit costs, a reduction in staff including the relocation of certain job functions, and the impairment of assets associated with the closure or partial closure of data centers and offices. The 2023-2024 Business Efficiency Program was finalized as of December 31, 2024. For additional information, see Note 4, "Business Optimization Initiatives," and Note 18, "Leases," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Pursuant to CMS' Medicare Advantage Star Ratings system, CMS annually awards between 1.0 and 5.0 Stars to Medicare Advantage plans based on performance in several categories. Plans must have a Star Rating of 4.0 or higher to qualify for bonus payments. Our 2024 Star Ratings, which are used for payment year 2025, reflect that 53% of our Medicare Advantage members were enrolled in plans rated at least 4.0 Stars or higher. This is an increase, based on subsequent recalculations by CMS, over the original 2024 Star Ratings from October 2023, which reflected that 34% of our Medicare Advantage members were enrolled in plans rated at least 4.0 Stars or higher.

CMS released our 2025 Star Ratings in October 2024, which will be used to determine our Medicare Advantage bonus payments in 2026. Our 2025 Star Ratings reflect that 38% of our Medicare Advantage members were enrolled in plans rated at least 4.0 Stars or higher. We expect this change will result in a reduction to our 2026 operating revenue of approximately $183 million, net of offsets from contracting provisions. Further, we expect to mitigate the financial impact to our 2026 operating gain and net income per share resulting from this change through various strategies such as contract diversification, operating expense efficiencies, capital deployment alternatives and network enhancements.

Business Acquisitions and Divestitures

Investments in Joint Ventures and Completed Acquisitions

On December 31, 2024, we completed our acquisition of Centers Plan for Healthy Living LLC and Centers for Specialty Care Group IPA, LLC ("Centers"). Centers is a managed long-term care plan that serves New York state Medicaid and dual-eligible Medicaid/Medicare members, enabling adults with long-term care needs and disabilities to live safely and independently in their own home. This acquisition aligns with our strategic plan to grow the Health Benefits segment and leverage industry-leading expertise while serving Medicaid and dual-eligible populations.

On December 10, 2024, we completed our acquisition of RSV QOZB LTSS, Inc. and certain affiliated entities (d/b/a CareBridge), a value-based healthcare company that manages home and community-based services for Medicaid and dual-eligible Medicaid/Medicare members receiving long-term services and support. This acquisition aligns with Carelon Services' care at home strategy, and our vision to be an innovative, valuable, and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve.

On August 6, 2024, as discussed in Note 5 “Investments,” we made an equity investment of $2,580 that resulted in our minority interest ownership of approximately 35% of Augusta Topco Holdings, L.P. (“Mosaic Health”), a joint venture with Clayton, Dubilier & Rice (“CD&R”) that is designed to accelerate innovation in care delivery across multiple regions in the United States by bringing together certain care delivery and enablement assets of Carelon Management Services, LLC (“CMSI Assets”), a Carelon Health business, and two CD&R portfolio businesses, apree health and Millennium Physician Group. Our additional contribution of the CMSI Assets to Mosaic Health was completed on January 1, 2025, for which we received an additional $300 of equity (approximately 5% ownership) in Mosaic Health. The CMSI Assets are included under the captions “Assets held for sale” and “Liabilities held for sale” in our consolidated balance sheets as of December 31, 2024.

On March 11, 2024, we completed our acquisition of Paragon Healthcare, Inc. and its subsidiaries (“Paragon”). Paragon, which operates as part of CarelonRx, provides infusion services and injectable therapies through its omnichannel model of ambulatory infusion centers, home infusion pharmacies, and other specialty pharmacy services. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve.

On February 15, 2023, we completed our acquisition of BioPlus Parent, LLC and its subsidiaries (“BioPlus”) from CarepathRx Aggregator, LLC. Prior to the acquisition, BioPlus was one of the largest independent specialty pharmacy organizations in the United States. BioPlus, which operates as part of CarelonRx, seeks to connect payors and providers of specialty pharmaceuticals to meet the medication therapy needs of patients with complex medical conditions. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve.

Divestiture

On April 1, 2024, we completed the sale of our life and disability businesses to StanCorp Financial Group, Inc. (“The Standard”), a provider of financial protection products and services for employers and individuals, which resulted in a gain on sale of business of $201 in the year ended December 31, 2024. Upon closing, we and The Standard entered into a product distribution partnership. The related net assets held for sale for the life and disability businesses divested as of December 31, 2023, and the results of operations for such businesses for the year ended December 31, 2024 were not material.

For additional information, see Note 3, “Business Acquisitions and Divestitures,” of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Litigation Matters

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA and Blue Cross and/or Blue Shield licensees (the “Blue plans”) across the country. Cases filed in 28 states were consolidated into a single, multi-district proceeding captioned *In re Blue Cross Blue Shield Antitrust Litigation* (“BCBSA Litigation”), that is pending before the U.S. District Court for the Northern District of Alabama (the “Court”). Generally, the lawsuits in the BCBSA Litigation challenge elements of the licensing agreements between the BCBSA and the independently owned and operated Blue plans. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers.

The BCBSA and Blue plans approved a settlement agreement and release with the subscriber plaintiffs (the “Subscriber Settlement Agreement”), and the ultimate amount paid by the Company under the Subscriber Settlement Agreement was $604, which was primarily accrued in 2020. The Subscriber Settlement Agreement and the defendants’ payment and non-monetary obligations under the Subscriber Settlement Agreement became effective in June 2024 with the request for the second Blue plan bid provision effective in September 2024. The funds held in escrow will be distributed in accordance with the Subscriber Settlement Agreement.

The BCBSA and the Blue plans have approved a settlement agreement and release (the “Provider Settlement Agreement”) with the provider plaintiffs, and in October 2024, the provider plaintiffs filed a motion for preliminary approval with the Court. The Court granted preliminary approval of the Provider Settlement Agreement on December 4, 2024. If approved by the Court, the Provider Settlement Agreement will require the defendants to make a monetary settlement payment, our portion of which is estimated to be $666, and will contain certain non-monetary terms including (i) expansion of certain opportunities to contract with providers in contiguous service areas, (ii) certain prompt pay commitments, and (iii)

various technological enhancements to the BlueCard program. We recognized our estimated payment obligation under the Provider Settlement Agreement of $666 in September 2024.

For additional information regarding the BCBSA Litigation, see Note 14, "Commitments and Contingencies – *Litigation and Regulatory Proceedings – Blue Cross Blue Shield Antitrust Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Selected Operating Performance

During the year ended December 31, 2024, total medical membership decreased by 1.1 million, or 2.3%. The decrease in medical membership was driven primarily by attrition in Medicaid membership, including as a result of eligibility redeterminations and certain market exits, and decreases in our Employer Group risk-based and Medicare Supplement businesses. These decreases were partially offset by increases in our Employer Group fee-based, Individual and FEP® businesses.

Operating revenue for the year ended December 31, 2024, was $175,204, an increase of $4,995, or 2.9%, from the year ended December 31, 2023. The increase in operating revenue was primarily driven by premium rate increases in all of our lines of business in recognition of medical cost trends, growth in CarelonRx product revenue and recent acquisitions. These increases were partially offset by declines in premiums driven by Medicaid membership attrition.

Net income for the year ended December 31, 2024, was $5,971, a decrease of $20, or 0.3%, from the year ended December 31, 2023. The decrease in net income was primarily due to a net decrease in our operating gain in our reportable segments and higher income tax expense, partially offset by increased net investment income, gain on the sale of our life and disability businesses and lower amortization of other intangible assets.

Our fully-diluted shareholders' EPS for the year ended December 31, 2024, was $25.68, an increase of $0.46, or 1.8%, from the year ended December 31, 2023. Our diluted shares for the year ended December 31, 2024 were 232.9, a decrease of 4.5, or 1.9%, compared to the year ended December 31, 2023. The increase in EPS resulted from fewer diluted shares outstanding.

Operating cash flow for the year ended December 31, 2024, was $5,808, or approximately 1.0 times net income. Operating cash flow for the year ended December 31, 2023 was $8,061, or approximately 1.3 times net income. The decrease in operating cash flow was primarily due to the impact of the membership decline in our Medicaid business and working capital changes.

Membership and Other Metrics

Our medical membership includes the following customer types: Individual, Employer Group risk-based, Employer Group fee-based, BlueCard®, Medicare, Medicaid and our FEP®. We refer to members in our service areas licensed by the BCBSA as our BCBS-branded, or Anthem BCBS, business. Non-BCBS-branded business refers to members in our non-BCBS-branded plans, which include Wellpoint, MMM and Simply Healthcare plans. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Public Exchanges. Individual business is sold on a risk-based basis. We offer on-exchange products through Public Exchanges and off-exchange products. Federal premium subsidies are available only for certain Public Exchange Individual products. Unsubsidized Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network and the efficiency of administration. Customer turnover is generally higher with Individual as compared to Employer Group risk-based. Individual business accounted for 2.8%, 2.2% and 1.7% of our medical members at December 31, 2024, 2023 and 2022, respectively.
- Employer Group risk-based consists of employer customers who purchase products on a full-risk basis, which are products for which we charge a premium and indemnify our policyholders against costs for health benefits. Employer Group risk-based accounts include Local Group customers and National Accounts. Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as

well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes Student Health members. National Accounts generally consist of multi-state employer groups primarily headquartered in an Elevance Health service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker and consultant relationships. Employer Group risk-based accounts are generally sold through brokers or consultants who work with industry specialists from our in-house sales force and are offered both on and off the Public Exchanges. Employer Group risk-based accounted for 8.1%, 8.0% and 8.4% of our medical members at December 31, 2024, 2023 and 2022, respectively.

- Employer Group fee-based customers represent employer groups, Local Group, and National Accounts, who purchase fee-based products and elect to retain most or all of the financial risk associated with their employees' healthcare costs. Some fee-based customers choose to purchase stop loss coverage to limit their retained risk. Employer Group fee-based accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. Employer Group fee-based accounted for 45.0%, 43.2% and 42.4% of our medical members at December 31, 2024, 2023 and 2022, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Elevance Health who receive healthcare services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Elevance Health subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Elevance Health controlled BCBSA licensee (the "home plan"). We perform certain functions, including claims pricing and administration, for BlueCard® members, for which we receive service fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan. Host members are computed using, among other things, the average number of BlueCard® claims received per month. BlueCard® host membership accounted for 14.5%, 14.3% and 13.8% of our medical members at December 31, 2024, 2023 and 2022, respectively.
- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, including Special Needs Plans ("SNPs"), also known as Medicare Advantage SNPs; dual-eligible programs through Medicare-Medicaid Plans ("MMPs"); Medicare Supplement plans; and Medicare Part D Prescription Drug Plans ("Medicare Part D"). Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage SNPs provide tailored benefits to special needs individuals who are institutionalized or have severe or disabling chronic conditions and to dual-eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Advantage SNPs are coordinated care plans specifically designed to provide targeted care, covering all the healthcare services considered medically necessary for members and often providing professional care coordination services, with personal guidance and programs that help members maintain their health. Medicare Advantage membership also includes Medicare Advantage members in our Group Retiree Solutions business who are retired members of commercial accounts or retired members of groups who are not affiliated with our commercial accounts who have selected a Medicare Advantage product through us. Medicare Supplement plans typically pay the difference between healthcare costs incurred by a beneficiary and amounts paid by Medicare. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP, which was established as a result of the passage of the ACA, is focused on serving members who are dually eligible for Medicaid and Medicare. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers. Medicare program business accounted for 6.5%, 6.3% and 6.1% of our medical members at December 31, 2024, 2023 and 2022, respectively.
- Medicaid membership represents eligible members who receive health benefits through publicly funded healthcare programs, including Medicaid, ACA-related Medicaid expansion programs, Temporary Assistance for Needy Families, programs for seniors and people with disabilities, Children's Health Insurance Programs, and specialty programs such as those focused on long-term services and support, HIV/AIDS, foster care, behavioral health and/or substance abuse disorders, and intellectual disabilities or developmental disabilities, among others. Total Medicaid program business accounted for 19.5%, 22.4% and 24.3% of our medical members at December 31, 2024, 2023 and 2022, respectively.

- FEP® members consist of United States government employees and their dependents who receive health benefits within our geographic markets. FEP® business accounted for 3.6%, 3.5% and 3.4% of our medical members at December 31, 2024, 2023 and 2022, respectively.

The following table presents our medical membership by customer type as of December 31, 2024, 2023 and 2022. Also included below is other membership by product and other metrics. The membership data and other metrics presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period. The CarelonRx Quarterly Adjusted Scripts metric represents adjusted script volume based on the number of days a prescription covers. On an adjusted basis, one 90-day script counts the same as three 30-day scripts. The Carelon Services Consumers Served metric represents the number of consumers receiving one or more healthcare related services from Carelon Services who are members of our affiliated health plans as well as those who are members of non-affiliated health plans.

				2024 vs. 2023		2023 vs. 2022	
	2024	2023	2022	Change	% Change	Change	% Change
Medical Membership *(in thousands)*							
Individual	1,287	1,025	789	262	25.6 %	236	29.9 %
Employer Group Risk-Based	3,713	3,756	3,988	(43)	(1.1)%	(232)	(5.8)%
Commercial Risk-Based	5,000	4,781	4,777	219	4.6 %	4	0.1 %
BlueCard®[1]	6,630	6,706	6,555	(76)	(1.1)%	151	2.3 %
Employer Group Fee-Based	20,569	20,227	20,174	342	1.7 %	53	0.3 %
Commercial Fee-Based	27,199	26,933	26,729	266	1.0 %	204	0.8 %
Medicare Advantage	2,066	2,047	1,977	19	0.9 %	70	3.5 %
Medicare Supplement	891	923	947	(32)	(3.5)%	(24)	(2.5)%
Total Medicare	2,957	2,970	2,924	(13)	(0.4)%	46	1.6 %
Medicaid	8,917	10,503	11,571	(1,586)	(15.1)%	(1,068)	(9.2)%
Federal Employee Program®	1,661	1,642	1,623	19	1.2 %	19	1.2 %
Total Medical Membership	45,734	46,829	47,624	(1,095)	(2.3)%	(795)	(1.7)%
Other Membership *(in thousands)*[2]							
Dental Members	7,282	6,820	6,692	462	6.8 %	128	1.9 %
Dental Administration Members	1,887	1,729	1,586	158	9.1 %	143	9.0 %
Vision Members	10,419	9,944	9,813	475	4.8 %	131	1.3 %
Medicare Part D Standalone Members	256	260	271	(4)	(1.5)%	(11)	(4.1)%
Other Metrics *(in millions)*							
CarelonRx Quarterly Adjusted Scripts	82.9	78.0	82.0	4.9	6.3 %	(4.0)	(4.9)%
Carelon Services Consumers Served	101.1	103.3	105.0	(2.2)	(2.1)%	(1.7)	(1.6)%

1 BlueCard® membership at December 31, 2023 and 2022 has been restated lower by 132 and higher by 93, respectively, to align to our current reporting, which is the BCBSA reporting methodology.

2 We are no longer presenting our Life and Disability membership following the sale of that business on April 1, 2024.

December 31, 2024 Compared to December 31, 2023

Medical Membership

Total medical membership declined during the twelve months ended December 31, 2024. This was driven primarily by attrition in Medicaid membership, including as a result of eligibility redeterminations and certain market exits, decreases in our Employer Group risk-based and Medicare Supplement businesses. These decreases were partially offset by increases in our Employer Group fee-based, Individual and FEP® businesses.

Other Membership

Our other membership has the potential to be impacted by changes in our medical membership, as our medical members often purchase our other products that are ancillary to our health business. Dental membership increased primarily due to favorable sales in our Individual, Employer Group fee-based and FEP® businesses. Dental Administration membership increased primarily due to favorable in-group change with our other BCBSA plans associated with the FEP®. Vision membership increased due to increased sales in our Employer Group fee-based and Individual businesses and increased sales associated with our Medicare Advantage plans.

Consolidated Results of Operations

Our consolidated summarized results of operations and other information for the years ended December 31, 2024, 2023 and 2022 are as follows:

	Years Ended December 31			Change			
				2024 vs. 2023		2023 vs. 2022	
	2024	2023	2022	$	%	$	%
Total operating revenue	$ 175,204	$ 170,209	$ 155,660	$ 4,995	2.9 %	$ 14,549	9.3 %
Net investment income	2,051	1,825	1,485	226	12.4 %	340	22.9 %
Net losses on financial instruments	(445)	(694)	(550)	249	(35.9)%	(144)	26.2 %
Gain on sales of business	201	—	—	201	100.0 %	—	— %
Total revenues	177,011	171,340	156,595	5,671	3.3 %	14,745	9.4 %
Benefit expense	127,567	124,330	116,642	3,237	2.6 %	7,688	6.6 %
Cost of products sold	19,750	17,293	13,035	2,457	14.2 %	4,258	32.7 %
Operating expense	20,025	20,087	17,700	(62)	(0.3)%	2,387	13.5 %
Other expense[1]	1,765	1,915	1,618	(150)	(7.8)%	297	18.4 %
Total expenses	169,107	163,625	148,995	5,482	3.4 %	14,630	9.8 %
Income before income tax expense	7,904	7,715	7,600	189	2.4 %	115	1.5 %
Income tax expense	1,933	1,724	1,712	209	12.1 %	12	0.7 %
Net income	5,971	5,991	5,888	(20)	(0.3)%	103	1.7 %
Net loss (gain) attributable to noncontrolling interests	9	(4)	6	13	NM	(10)	NM
Shareholders' net income	$ 5,980	$ 5,987	$ 5,894	$ (7)	(0.1)%	$ 93	1.6 %
Average diluted shares outstanding	232.9	237.4	242.8	(4.5)	(1.9)%	(5.4)	(2.2)%
Diluted shareholders' earnings per share	$ 25.68	$ 25.22	$ 24.28	$ 0.46	1.8 %	$ 0.94	3.9 %
Effective tax rate	24.5 %	22.3 %	22.5 %		200 bp[3]		(20) bp[3]
Benefit expense ratio[2]	88.5 %	87.0 %	87.6 %		150 bp[3]		(60) bp[3]
Operating expense ratio[4]	11.4 %	11.8 %	11.4 %		(40) bp[3]		40 bp[3]
Income before income tax expense as a percentage of total revenues	4.5 %	4.5 %	4.9 %		0 bp[3]		(40) bp[3]
Shareholders' net income as a percentage of total revenues	3.4 %	3.5 %	3.8 %		(10) bp[3]		(30) bp[3]

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

NM Not meaningful.

1 Includes interest expense and amortization of other intangible assets.

2 Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the years ended December 31, 2024, 2023 and 2022 were $144,166, $142,854 and $133,229, respectively. Premiums are included in total operating revenue presented above.

3 bp = basis point; one hundred basis points = 1%.

4 Operating expense ratio represents operating expense as a percentage of total operating revenue.

Year Ended December 31, 2024 Compared to the Year Ended December 31, 2023

Total operating revenue increased primarily as a result of premium rate increases in all of our lines of business in recognition of medical cost trends, growth in CarelonRx product revenue and recent acquisitions. These increases were partially offset by declines in premiums driven by Medicaid membership attrition.

Net investment income increased primarily due to higher income from fixed maturity securities and alternative investments.

Net losses on financial instruments decreased due to increased gains on fixed maturity securities, partially offset by losses on strategic investments and equity securities.

During the twelve months ended December 31, 2024, we experienced a gain on sale of business due to the sale of our life and disability business.

Benefit expense increased primarily due to increases in medical cost trends in our Health Business segment due to Medicaid membership eligibility redeterminations. These increases were partially offset by declines driven by Medicaid membership attrition.

Our benefit expense ratio increased, primarily driven by higher Medicaid membership cost trends due to Medicaid rates being inadequate to cover medical cost trends that were well in excess of historical averages, primarily due to the Medicaid membership redeterminations.

Cost of products sold reflects the cost of pharmaceuticals dispensed by CarelonRx for our unaffiliated pharmacy customers. Cost of products sold increased as a result of higher script utilization.

Operating expense decreased primarily due to disciplined cost management, enhanced efficiency and lower business optimization charges, partially offset by the accrual for the Provider Settlement Agreement associated with the BCBSA Litigation.

Our operating expense ratio decreased primarily due to disciplined cost management, enhanced efficiency, lower business optimization charges and the favorable impact of operating revenue growth, partially offset by the accrual for the Provider Settlement Agreement associated with the BCBSA Litigation.

Other expense decreased primarily due to decreased amortization of intangible assets during the twelve months ended December 31, 2024. During the twelve months ended December 31, 2023, we had increased amortization of other intangible assets as the amortization period of certain assets was shortened to align with the dates our new branding took place.

Our effective income tax rate increased from 22.3% to 24.5%, primarily due to the impact of geographic changes in the mix of our 2024 earnings.

Our shareholders' net income as a percentage of total revenues slightly decreased in 2024 as compared to 2023 as a result of all the factors discussed above.

Reportable Segments Results of Operations

The following table presents a summary of our reportable segment financial information for the years ended December 31, 2024, 2023 and 2022:

	Years Ended December 31			Change			
				2024 vs. 2023		2023 vs. 2022	
	2024	2023	2022	$	%	$	%
Operating Revenue							
Health Benefits	$ 150,275	$ 148,571	$ 138,484	$ 1,704	1.1 %	$ 10,087	7.3 %
CarelonRx	35,961	33,835	28,526	2,126	6.3 %	5,309	18.6 %
Carelon Services	17,961	14,147	12,860	3,814	27.0 %	1,287	10.0 %
Corporate & Other	309	479	399	(170)	(35.5)%	80	20.1 %
Eliminations	(29,302)	(26,823)	(24,609)	(2,479)	9.2 %	(2,214)	9.0 %
Total operating revenue	$ 175,204	$ 170,209	$ 155,660	$ 4,995	2.9 %	$ 14,549	9.3 %
Operating Gain (Loss)							
Health Benefits	$ 6,243	$ 6,888	$ 6,022	$ (645)	(9.4)%	$ 866	14.4 %
CarelonRx	2,172	1,975	1,868	197	10.0 %	107	5.7 %
Carelon Services	717	680	535	37	5.4 %	145	27.1 %
Corporate & Other	(1,270)	(1,044)	(142)	(226)	21.6 %	(902)	635.2 %
Operating Margin							
Health Benefits	4.2 %	4.6 %	4.3 %		(40) bp		30 bp
CarelonRx	6.0 %	5.8 %	6.5 %		20 bp		(70) bp
Carelon Services	4.0 %	4.8 %	4.2 %		(80) bp		60 bp

The following table summarizes Health Benefits operating revenues by Commercial, Medicare, Medicaid and FEP® lines of business for the years ended December 31, 2024, 2023 and 2022:

	Years Ended December 31			Change			
				2024 vs. 2023		2023 vs. 2022	
	2024	2023	2022	$	%	$	%
Health Benefits Operating Revenue							
Commercial	$ 46,816	$ 43,266	$ 41,674	$ 3,550	8.2 %	$ 1,592	3.8 %
Medicare	36,795	35,067	31,604	1,728	4.9 %	3,463	11.0 %
Medicaid	51,937	56,601	52,886	(4,664)	(8.2)%	3,715	7.0 %
Federal Employee Program®	14,727	13,637	12,320	1,090	8.0 %	1,317	10.7 %
Total Health Benefits operating revenues	$ 150,275	$ 148,571	$ 138,484	$ 1,704	1.1 %	$ 10,087	7.3 %

Year Ended December 31, 2024 Compared to the Year Ended December 31, 2023

Health Benefits

Operating revenue increased primarily as a result of higher premium yields driven by premium rate increases in all of our lines of business in recognition of medical cost trends, partially offset by membership attrition in our Medicaid business.

The decrease in operating gain was primarily a result of Medicaid rates being inadequate to cover medical cost trends that were well in excess of historical averages due to Medicaid membership eligibility redeterminations, partially offset by improved premium yields in our other Health Benefits businesses.

CarelonRx

Operating revenue increased primarily as a result of higher prescription volume associated with growth in external pharmacy members and the recent acquisition of Paragon, partially offset by the impact of Medicaid membership attrition.

The increase in operating gain was primarily a result of the growth in product revenue, partially offset by expenses associated with the launch of additional services by CarelonRx.

Carelon Services

Operating revenue increased primarily due to the continued expansion of our medical benefit management, behavioral health and post-acute care services, as well as acquisitions completed in 2024.

The increase in operating gain was primarily driven by improved performance in Carelon Services businesses, partially offset by increased medical cost trends in our post-acute business and the impact of Medicaid membership attrition.

Corporate & Other

The increase in operating loss was primarily due to the accrual recorded for the Provider Settlement Agreement associated with the BCBSA Litigation, partially offset by disciplined cost management and lower business optimization charges.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, goodwill and other intangible assets and investments, which are discussed below. Our other significant accounting policies are summarized in Note 2, "Basis of Presentation and Significant Accounting Policies," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We continually evaluate the accounting policies and estimates used to prepare the consolidated financial statements. In general, our estimates are based on historical experience, evaluation of current trends, information from third-party professionals and various other assumptions that we believe to be reasonable under the known facts and circumstances. Estimates can require a significant amount of judgment, and a different set of assumptions could result in material changes to our reported results.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2024, this liability was $15,746 and represented 20.9% of our total liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims, including the estimated costs of processing such claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported; as well as (2) claims reported to us but not yet processed through our systems, which approximated 97.5%, or $15,347, of our total medical claims liability as of December 31, 2024; and (3) claims reported to us and processed through our systems but not yet paid, which approximated 2.5%, or $399 of the total medical claims payable as of December 31, 2024. The level of claims payable processed through our systems but not yet paid may fluctuate from one period-end to the next, from approximately 2% to 6% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Our reserving practice for claim liabilities is to consistently recognize the appropriate amount of reserve within a level of confidence required by Actuarial Standards of Practice. We determine the amount of the liability for incurred but not yet reported or processed claims by following a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into "claim triangles," which compare claim incurred dates to the dates of claim

payments. This information is analyzed to create “completion factors” that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels (“trend factors”).

Our reserve methodology, which relies upon historical information, must be adjusted to account for known or suspected operational and environmental changes. Adjustments are carried out by our actuaries, drawing on expert knowledge and taking into account their estimate of emerging impacts to benefit costs and payment speed. Factors such as changes in levels of utilization, unit costs, business mix, benefit plan designs, provider reimbursements, processing system modifications, claim inventory levels, claim processing and submission patterns, and operational changes resulting from business combinations are considered when developing our reserve estimates. We also compare prior period liabilities to revised claim liabilities based on subsequent claim development. In these comparisons, methods and assumptions remain constant as reserves are recalculated; rather, the availability of additional paid claims information drives changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense.

On a regular basis, we review cost trends and utilization assumptions set upon initial establishment of claim liabilities. We utilize subsequent paid claims activity to monitor and continuously adjust the claims liability and benefit expense. If actual results are determined to be materially different than assumptions regarding cost trends and utilization, future periods of our income statement and overall financial position could be impacted. Adjustments made to prior year estimates may result in either an additional benefit expense or a reduction of benefit expense in the period the adjustment is made. The variability of healthcare costs necessitates that claim liabilities be adjusted each period and are sometimes significant compared to the net income recorded in that period. An actuary’s judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued triggers the immediate recognition of prior period development. Once sufficient information is available to ascertain that the re-estimate of the liability is reasonable, the determination is made.

While numerous factors contribute to our medical claims payable liability estimation, the two assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2024, were the completion and trend factors. These vital assumptions can be affected by variables such as utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing and submission patterns, and operational changes resulting from business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2024, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower estimated variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions results in variability of 2%, or approximately $295, in the December 31, 2024 incurred but not paid claims liability, depending on the completion factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2024 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2024, there was a 380 basis point differential in the high and low trend factors. This range of trend factors would imply variability of 4%, or approximately $560, in the incurred but

not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2024.

See Note 12, "Medical Claims Payable," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2024, 2023 and 2022. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 12, "Medical Claims Payable," the line labeled "Net incurred medical claims: Prior years redundancies" accounts for those adjustments made to prior year estimates. The impact of any reduction of "Net incurred medical claims: Prior years redundancies" may be offset as we establish the estimate of "Net incurred medical claims: Current year", or as we establish liabilities for premium refunds based upon the minimum medical loss ratio ("MLR"), the relative health risk of members, and other contractual or regulatory requirements. Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 88.5% for 2024, 88.0% for 2023 and 87.3% for 2022. This ratio serves as an indicator of claims processing speed whereby 2024 claims were processed at a similar speed to 2023 and 2022.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred claims payable less prior year redundancies in the current year in order to demonstrate the development of the prior year reserves. For the year ended December 31, 2024, this metric was 12.3%, largely driven by favorable completion factor development from 2023 as well as favorable trend factor development at the end of 2023. For the year ended December 31, 2023, this metric was 11.4% and was largely driven by favorable trend factor development at the end of 2022 as well as favorable completion factor development from 2022. For the year ended December 31, 2022, this metric was 7.0% and was largely driven by favorable trend factor development at the end of 2021.

We calculate the percentage of prior year redundancies in the current year as a percent of prior year net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims. For the year ended December 31, 2024, this metric was 1.4%, which was calculated using the redundancy of $1,731. This metric was 1.4% for 2023 and 0.9% for 2022.

The following table shows the variance between total net incurred medical claims as reported in Note 12, "Medical Claims Payable," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, for each of 2023 and 2022 and the incurred claims for such years had it been determined retrospectively (computed as the difference between "net incurred medical claims – current year" for the year shown and "net incurred medical claims – prior years redundancies" for the immediately following year):

	Years Ended December 31	
	2023	2022
Total net incurred medical claims, as reported	$ 120,227	$ 112,545
Retrospective basis, as described above	120,067	111,843
Variance	$ 160	$ 702
Variance to total net incurred medical claims, as reported	0.1 %	0.6 %

Given that our business is primarily short tailed (which means that medical claims are generally paid within twelve months of the member receiving service from the provider), the variance to total net incurred medical claims, as reported above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2024 estimate of medical claims payable will be known during 2025.

The 2023 variance to total net incurred medical claims, as reported, of 0.1% was less than the 2022 percentage of 0.6%. This was primarily driven by the fact that the change in prior year redundancy reported for 2023 as compared to 2022 was less than the change in the prior year redundancy reported for 2022 as compared to 2021.

Goodwill and Other Intangible Assets

Our total goodwill and other intangible assets at December 31, 2024 were $40,371, and represented 34.5% of our total assets and 97.5% of our total equity at December 31, 2024.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. Furthermore, goodwill and other intangible assets are allocated to reporting units for purposes of the annual impairment test. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, which include goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of goodwill at the reporting unit level and other intangible assets with indefinite lives, and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. We have the option of first performing a qualitative assessment for each reporting unit to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, which is an indication that our goodwill may be impaired. These qualitative impairment tests include assessing events and factors that could affect the fair value of the indefinite-lived intangible assets. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors and entity specific events. If we determine that a reporting unit's goodwill may be impaired after utilizing these qualitative impairment analysis procedures, we are required to perform a quantitative impairment test.

Our quantitative impairment test utilizes the projected income and market valuation approaches for goodwill and the projected income approach for our indefinite lived intangible assets. Use of the projected income and market valuation approaches for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry's weighted-average cost of capital. Market valuations are based on observed multiples of certain measures including revenue; earnings before interest, taxes, depreciation and amortization; and book value of invested capital (debt and equity) and include market comparisons to publicly traded companies in our industry.

We did not incur any impairment losses as a result of our 2024 annual impairment tests, as it was determined that it is more likely than not that the estimated fair values of our reporting units were substantially in excess of the carrying values as of December 31, 2024. Additionally, we do not believe that the estimated fair values of our reporting units are at risk of becoming impaired in the next twelve months.

If estimated fair values are less than the carrying values of goodwill and other intangibles with indefinite lives in future annual impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 3, "Business Acquisitions and Divestitures," and Note 10, "Goodwill and Other Intangible Assets," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Investments

Current and long-term marketable investment securities were $27,428 at December 31, 2024 and represented 23.5% of our total consolidated assets at December 31, 2024. We classify fixed maturity securities in our investment portfolio as "available-for-sale" and report those securities at fair value. Most fixed maturity securities are available to support current

operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

Our impairment review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both qualitative and quantitative factors. Such factors considered include the extent to which a security's market value has been less than its cost, the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors), financial condition and near term prospects of the issuer, including the credit ratings and changes in the credit ratings of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends.

If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, we write down the fixed maturity security's cost basis to fair value and record an impairment loss in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or if it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, we recognize the credit component of the impairment as an allowance for credit loss in our consolidated balance sheets and record an impairment loss in our consolidated statements of income. The non-credit component of the impairment is recognized in accumulated other comprehensive (loss) income. Furthermore, unrealized losses entirely caused by non-credit-related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive (loss) income.

The credit component of an impairment is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of purchase. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral, including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

We have a committee of accounting and investment associates and management that is responsible for managing the impairment review process. We believe that we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. We have established an allowance for credit loss and recorded credit loss expense as a reflection of our expected impairment losses. Given the inherent uncertainty of changes in market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and additional impairment losses on investments may be recorded in future periods.

In addition to marketable investment securities, we held additional long-term investments of $9,749, or 8.3% of total consolidated assets, at December 31, 2024. These long-term investments consisted primarily of certain other equity investments, the cash surrender value of corporate-owned life insurance policies, notes receivables and mortgage loans. Due to their less liquid nature, these investments are classified as long-term.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage market risks through our investment policy, which establishes credit quality limits and limits on investments in individual issuers. Ineffective management of these risks could have an impact on our future results of operations and financial condition. Our investment portfolio includes fixed maturity securities with a fair value of $26,236 at December 31, 2024. The weighted-average credit rating of these securities was "A" as of December 31, 2024. Included in this balance are investments in fixed maturity securities of states, municipalities and political subdivisions of $835 that are guaranteed by third parties. With the exception of 14 securities with a fair value of $8, these securities are all investment-grade and carry a weighted-average credit rating of "AA" as of December 31, 2024. The securities are guaranteed by a number of different guarantors, and we do not have any material exposure to any single guarantor, neither indirectly through the guarantees, nor directly through investment in the guarantor. Further, the weighted-average credit rating of the fixed maturity securities without a guarantee, for which such information is available, was "A" as of December 31, 2024.

Fair values of fixed maturity and equity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value in accordance with FASB guidance for fair value measurements and disclosures. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

We obtain quoted market prices for each security from the pricing services, which are derived through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available market observable information. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in these valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2024 and 2023.

In certain circumstances, it may not be possible to derive pricing model inputs from observable market activity, and therefore, such inputs are estimated internally. Such securities are designated Level III in accordance with FASB guidance. Securities designated Level III at December 31, 2024 totaled $872 and represented approximately 2.6% of our total assets measured at fair value on a recurring basis. Our Level III securities primarily consisted of certain corporate securities and equity securities for which observable inputs were not always available and the fair values of these securities were estimated using inputs including, but not limited to, prepayment speeds, credit spreads, default rates and benchmark yields.

For additional information, see Part II, Item 7A, "Quantitative and Qualitative Disclosures about Market Risk" of this Annual Report on Form 10-K and Note 2, "Basis of Presentation and Significant Accounting Policies," Note 5, "Investments," and Note 7, "Fair Value," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were issued or became effective during the year ended December 31, 2024 that had, or are expected to have, a material impact on our financial position, results of operations or financial statement disclosures, see the "*Recently Adopted Accounting Guidance*" and *"Recent Accounting Guidance Not Yet Adopted"* sections of Note 2, "Basis of Presentation and Significant Accounting Policies," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Liquidity and Capital Resources

Introduction

Our cash receipts result primarily from premiums, product revenue, service fees, investment income, proceeds from the sale or maturity of our investment securities, proceeds from business divestitures, proceeds from borrowings and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, operating expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

We manage our cash, investments and capital structure so that we are able to meet the short-term and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable investment and financing within the overall constraints of our financial strategy.

A substantial portion of the assets held by our regulated subsidiaries are in the form of cash and cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash that exceeds our near-term obligations in longer term marketable fixed maturity securities to improve our overall investment income returns. Our investment strategy is to make investments consistent with insurance statutes and other regulatory requirements, while preserving our asset base. Our investments are generally available-for-sale to meet liquidity and other needs. Our subsidiaries pay out excess capital annually in the form of dividends to their respective parent companies for general corporate use, as permitted by applicable regulations.

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. The securities and credit markets have in the past experienced higher than normal volatility. Interest rates on fixed debt income securities have increased since the beginning of 2022, which may increase our borrowing costs if we elect to issue debt. During recent years, the federal government and various governmental agencies have taken a number of steps to strengthen the regulation of the financial services market. In addition, governments around the world have developed their own plans to provide stability and security in the credit markets and to ensure adequate capital in certain financial institutions.

A summary of our major sources and uses of cash and cash equivalents for the years ended December 31, 2024, 2023 and 2022 is as follows:

	Years Ended December 31			$ Change	
	2024	2023	2022	2024 vs. 2023	2023 vs. 2022
Sources of Cash:					
Net cash provided by operating activities	$ 5,808	$ 8,061	$ 8,399	$ (2,253)	$ (338)
Proceeds from sales, maturities, calls and redemptions of investments, net of purchases	586	—	—	586	—
Issuances of short- and long-term debt, net of repayments	6,200	626	862	5,574	(236)
Issuances of common stock under employee stock plans	221	152	182	69	(30)
Other sources of cash, net	—	—	762	—	(762)
Total sources of cash	12,815	8,839	10,205	3,976	(1,366)
Uses of Cash:					
Purchases of investments, net of proceeds from sales, maturities, calls and redemptions	—	(2,700)	(2,338)	2,700	(362)
Repurchase and retirement of common stock	(2,900)	(2,676)	(2,316)	(224)	(360)
Purchases of subsidiaries, net of cash acquired	(4,809)	(1,552)	(649)	(3,257)	(903)
Purchases of property and equipment	(1,256)	(1,296)	(1,152)	40	(144)
Cash dividends	(1,508)	(1,395)	(1,229)	(113)	(166)
Other uses of cash, net	(508)	(80)	—	(428)	(80)
Total uses of cash	(10,981)	(9,699)	(7,684)	(1,282)	(2,015)
Effect of foreign exchange rates on cash and cash equivalents	(6)	(1)	(14)	(5)	13
Net increase (decrease) in cash and cash equivalents	$ 1,828	$ (861)	$ 2,507	$ 2,689	$ (3,368)

Liquidity—Year Ended December 31, 2024 Compared to Year Ended December 31, 2023

The decline in cash provided by operating activities was primarily due to the impact of the membership decline in our Medicaid business and working capital changes.

Other significant changes in sources and uses of cash year-over-year included (a) additional sources of cash from issuances of short- and long-term debt, net of repayments, proceeds from sales, maturities, calls and redemptions of investments, net of purchases, and issuances of common stock under employee stock plans and (b) increased uses of cash from purchases of subsidiaries, net of cash acquired, the repurchase and retirement of common stock, the purchase of property and equipment, cash dividends, and other uses of cash, net.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments in fixed maturity and equity securities of $35,716 at December 31, 2024. Since December 31, 2023, total cash, cash equivalents and investments in fixed maturity and equity securities decreased by $1,529, primarily due to cash used for common stock repurchases, purchases of subsidiaries net of cash acquired, purchases of property and equipment and cash dividends paid to shareholders. This decrease was partially offset by cash generated from operations, issuances of short-and-long term debt, net of repayment, proceeds from sales, maturities, calls, and redemptions, and issuances of common stock.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory accounting practices, if any, or other regulatory requirements, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At December 31, 2024, we held $2,357 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Periodically, we access capital markets and issue debt ("Notes") for long-term borrowing purposes, for example, to refinance debt, to finance acquisitions or for share repurchases. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating. For more information on our debt, including redemptions and issuances, see Note 13, "Debt," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, from the amounts presented on our audited consolidated balance sheets included in Part II, Item 8 of this Annual Report on Form 10-K. Our debt-to-capital ratio is calculated as total debt divided by total debt plus total equity. Total debt is the sum of short-term borrowings, current portion of long-term debt and long-term debt, less current portion. We believe our debt-to-capital ratio assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 43.0% and 38.9% as of December 31, 2024 and 2023, respectively.

Our senior debt is rated "A" by S&P Global Ratings, "BBB+" by Fitch Ratings, Inc., "Baa2" by Moody's Investors Service, Inc. and "bbb+" by AM Best Company, Inc. We intend to maintain our senior debt investment grade ratings. If our credit ratings are downgraded, our business, liquidity, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs.

Capital Resources

We have a shelf registration statement on file with the U.S. Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansions.

We have a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. The 5-Year Facility provides credit of up to $4,000 and matures in April 2027. Our ability to borrow under the 5-Year Facility is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the credit agreement for the 5-Year Facility. As of December 31, 2024, our debt-to-capital ratio, as defined and calculated under the 5-Year Facility, was 43.0%. We do not believe the restrictions contained in our 5-Year Facility covenants materially affect our financial or operating

flexibility. As of December 31, 2024, we were in compliance with all of our debt covenants under the 5-Year Facility. There were no amounts outstanding under the 5-Year Facility at December 31, 2024.

We have an authorized commercial paper program of up to $4,000, the proceeds of which may be used for general corporate purposes. Should commercial paper issuance become unavailable, we have the ability to use a combination of cash on hand and/or our 5-Year Facility, which provides for credit in the amount of $4,000, to redeem any outstanding commercial paper upon maturity. At December 31, 2024, we had $0 outstanding under our commercial paper program. Beginning June 30, 2023, we have reclassified our commercial paper balances from long-term debt to short-term debt as our intent is to not replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year.

While there is no assurance in the current economic environment, we believe the lenders participating in our 5-Year Facility, if market conditions allow, would be willing to provide financing in accordance with their legal obligations.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, the Federal Home Loan Bank of Atlanta and the Federal Home Loan Bank of New York (collectively the "FHLBs"). As a member, we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2024, we had $365 of outstanding short-term borrowings from the FHLBs.

As discussed in "*Financial Condition*" above, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid. Based upon these requirements, we currently estimate that approximately $2,700 of dividends will be paid to us by our subsidiaries during 2025. During 2024, we received $6,322 of dividends from our subsidiaries.

In addition to regulations regarding the timing and amount of dividends, our regulated subsidiaries' states of domicile have statutory risk-based capital ("RBC") requirements for health and other insurance companies and health maintenance organizations largely based on the National Association of Insurance Commissioners (the "NAIC") Risk-Based Capital (RBC) for Health Organizations Model Act (the "RBC Model Act"). These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer's investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries' respective RBC levels as of December 31, 2024 were in excess of all applicable mandatory RBC requirements. In addition to exceeding these RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net worth requirements applicable to certain of our California subsidiaries. For additional information, see Note 22, "Statutory Information," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Future Sources and Uses of Liquidity

Short-Term Liquidity Requirements

As previously described, our cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. We believe cash on hand, operating cash receipts, investments and amounts available under our commercial paper program, our 5-Year Facility and borrowings available from the FHLBs will be adequate to fund our expected cash disbursements over the next twelve months.

Long-Term Liquidity Requirements

As of December 31, 2024, our long-term cash disbursements required under various contractual obligations and commitments were:

- *Debt and interest expense:* Future debt and estimated interest payments are $52,073, with $2,855 due within the next twelve months. For additional information, see Note 13, "Debt," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.
- *Operating leases:* We lease office space and certain computer equipment, for which the future estimated payments were $886, with $184 due within the next twelve months. For additional information, see Note 18, "Leases," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.
- *Other liabilities:* These liabilities primarily consist of future policy reserves, projected other postretirement benefits, deferred compensation, supplemental executive retirement plan liabilities and certain other miscellaneous long-term obligations. Amounts due within twelve months were $35, with $1,956 due in future periods. Estimated future payments for funded pension benefits have been excluded from these numbers, as we had no funding requirements under the Employee Retirement Income Security Act of 1974, as amended, at December 31, 2024, as a result of the value of the assets in the plans. In addition, gross liabilities for uncertain tax positions and interest for which we cannot reasonably estimate the timing of the resolutions with the respective taxing authorities have not been included. For further information, see Note 8, "Income Taxes," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.
- *Purchase obligations:* These obligations include estimated payments for future services under contractual arrangements from third-party service vendors. Amounts due within the next twelve months for these purchase obligations were $995, while longer term payments were $3,891. For further information, see Note 14, "Commitments and Contingencies," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.
- *Investment commitments:* These include unfunded capital commitments for alternative investments and low-income housing tax credits. Estimated amounts due were $1,444, including $409 due within the next twelve months.

In addition to the contractual obligations and commitments discussed above, we have a variety of other contractual agreements related to acquiring materials and services used in our operations. However, we do not believe these other agreements contain material noncancelable commitments.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

On January 22, 2025, our Audit Committee declared a quarterly cash dividend to shareholders of $1.71 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 25, 2025 to the shareholders of record as of March 10, 2025.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. As of December 31, 2024, we had Board authorization of $9,300 to repurchase our common stock. No duration has been placed on our common stock repurchase program, and we reserve the right to discontinue the program at any time. We intend to utilize this authorization over a multi-year period, subject to market and industry conditions.

We believe that funds from future operating cash flows, cash and investments and funds available under our credit facilities and/or from public or private financing sources will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

Other than disclosed in the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K, we do not have any off-balance sheet derivative instruments, guarantee transactions, agreements or other contractual arrangements or any indemnification agreements that will require funding in future periods. We have not transferred assets to an unconsolidated entity that serves as credit, liquidity or market risk support to such entity. We do not hold any variable interest in an unconsolidated entity where such entity provides us with financing, liquidity, market risk or

credit risk support. See Note 2, “Subsidiary Transactions,” of the Notes to Condensed Financial Statements (Parent Company Only) included in Part IV, Item 15 of this Annual Report on Form 10-K for additional detail on the Elevance Health, Inc. parent guarantees of certain subsidiaries.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

(In Millions, Except As Otherwise Stated Herein)

As a result of our investing and borrowing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in market valuations. Potential impacts discussed below are based upon sensitivity analyses performed on our financial position as of December 31, 2024. Actual results could vary from these estimates. Our primary objectives with our investment portfolio are to provide safety and preservation of capital, sufficient liquidity to meet cash flow requirements, the integration of investment strategy with the business operations and an attainment of a competitive after-tax total return.

Investments

Our investment portfolio is exposed to three primary sources of risk: credit quality risk, interest rate risk and market valuation risk.

The primary risks associated with our fixed maturity securities, which are classified as available-for-sale, are credit quality risk and interest rate risk. Credit quality risk is defined as the risk of a credit event, such as a ratings downgrade or default, to an individual fixed maturity security and the potential loss attributable to that event. Credit quality risk is managed through our investment policy, which establishes credit quality limitations on the overall portfolio as well as diversification and percentage limits on securities of individual issuers. The result is a well-diversified portfolio of fixed maturity securities, with an average credit rating of approximately “A.” Interest rate risk is defined as the potential for economic losses on fixed maturity securities due to a change in market interest rates. Our fixed maturity portfolio is invested primarily in U.S. government securities, corporate bonds, asset-backed bonds, mortgage-related securities and municipal bonds, all of which have exposure to changes in the level of market interest rates. Interest rate risk is managed by maintaining asset duration within a band based upon our liabilities, operating performance and liquidity needs. Additionally, we have the capability of holding any security to maturity, which would allow us to realize full par value.

Investments in fixed maturity securities include corporate securities, which account for 53% of our total fixed maturity securities at December 31, 2024 and are subject to credit/default risk. In a declining economic environment, corporate yields will usually increase, prompted by concern over the ability of corporations to make interest payments, thus causing a decrease in the price of corporate securities, and the decline in value of the corporate fixed maturity portfolio. We manage this risk through fundamental credit analysis, diversification of issuers and industries and an average credit rating of our corporate fixed maturity portfolio of approximately “BBB.”

Market risk for fixed maturity securities is addressed by actively managing the duration, allocation and diversification of our investment portfolio. We have evaluated the impact on the fixed maturity portfolio’s fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate $1,424 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate $1,527 increase in fair value. While we classify our fixed maturity securities as “available-for-sale” for accounting purposes, we believe our cash flows and the duration of our portfolio should allow us to hold securities to maturity, thereby avoiding the recognition of losses should interest rates rise significantly.

Our equity portfolio is comprised of large capitalization and small capitalization exchange-traded funds, domestic equities, foreign equities and index mutual funds. Our equity portfolio is subject to the volatility inherent in the stock market, driven by concerns over economic conditions, earnings and sales growth, inflation, and consumer confidence. These systemic risks cannot be managed through diversification alone. However, more routine risks, such as stock/industry specific risks, are managed by investing in a diversified equity portfolio.

Our other invested assets, reported within our long-term investments, are primarily subject to private market exposures, including private equity and private credit investments. These investments are also subject to credit quality risk, interest rate risk and market valuation risk, as public market valuations will form a basis for valuations for these investments. Given their

illiquid nature, we focus on appropriate sizing of these investments relative to our liquidity needs and risk tolerance. Our risk tolerance is formed by the level of illiquidity and short-term price movements from market valuation risk we are willing to accept relative to the higher long-term expected returns over the life of these investments.

As of December 31, 2024, 4% of our marketable investments were equity securities. An immediate 10% decrease in each equity investment's value, arising from market movement, would result in a fair value decrease of $119. Alternatively, an immediate 10% increase in each equity investment's value, attributable to the same factor, would result in a fair value increase of $119.

For additional information regarding our investments, see Note 5, "Investments," of the Notes to Consolidated Financial Statements included in Part II, Item 8 and "Critical Accounting Policies and Estimates - *Investments*" within Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Long-Term Debt

Our total long-term debt at December 31, 2024 consisted of senior unsecured notes and subordinated surplus notes issued by one of our insurance subsidiaries. At December 31, 2024, the carrying value and estimated fair value of our long-term debt was $30,867 and $28,460, respectively. This debt is subject to interest rate risk, as these instruments have fixed interest rates and the fair value is affected by changes in market interest rates. Should interest rates increase or decrease in the future, the estimated fair value of our fixed rate debt would decrease or increase accordingly.

For additional information regarding our long-term debt, see Note 7, "Fair Value," and Note 13, "Debt," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Derivatives

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through the use of derivative financial instruments. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge (on an economic basis) interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

Changes in interest rates will affect the estimated fair value of these derivatives. As of December 31, 2024, we recorded a net liability of $142, the estimated fair value of the swaps at that date. We have evaluated the impact on the interest rate swaps' fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate $383 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate $383 increase in fair value.

For additional information regarding our derivatives, see Note 6, "Derivative Financial Instruments," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

Elevance Health, Inc.

CONSOLIDATED FINANCIAL STATEMENTS

Years ended December 31, 2024, 2023 and 2022

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Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Elevance Health, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Elevance Health, Inc. (the Company) as of December 31, 2024 and 2023, the related consolidated statements of income, comprehensive income, cash flows and shareholders' equity for each of the three years in the period ended December 31, 2024, and the related notes and financial statement schedule listed in the Index at Item 15(c) (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2024 and 2023, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2024, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2024, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 20, 2025 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of the critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the account or disclosure to which it relates.

Valuation of Incurred but Not Paid Claims

Description of the Matter	Medical claims payable was $15,746 million at December 31, 2024, a significant portion of which related to the Company's estimate for claims that are incurred but not paid. As discussed in Note 2 to the consolidated financial statements, the Company's liability for incurred but not paid claims is determined using actuarial methods that include a number of factors and assumptions, including completion factors, which represent the average percentage of total incurred claims that have been paid through a given date after being incurred, and trend factors, which represent an estimate of claims expense based on recent claims expense levels and healthcare cost levels. There is significant uncertainty inherent in determining management's best estimate of completion and trend factors, which are used to calculate actuarial estimates of incurred but not paid claims. Auditing management's estimate of incurred but not paid claims was complex and required the involvement of our actuarial specialists due to the highly judgmental nature of the completion and trend factor assumptions used in the valuation process. The significant judgment was primarily due to the sensitivity of management's best estimate of completion and trend factor assumptions, which have a significant impact on the valuation of incurred but not paid claims.
How We Addressed the Matter in Our Audit	We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's actuarial process for estimating the liability for incurred but not paid claims. These audit procedures included among others, testing management review controls over completion and trend factor assumptions and the review and approval processes that management has in place for estimating the liability for incurred but not paid claims. To test the Company's liability for incurred but not paid claims, our audit procedures included, among others, testing the completeness and accuracy of the underlying claims and membership data recorded in the source claims processing and disbursement systems to the data used by management in developing completion and trend factor assumptions and agreeing a sample of incurred and paid claims to source documentation. With the support of actuarial specialists, we evaluated the methodologies applied by the Company in determining the actuarially determined liability and management's actuarial assumptions, including trend and completion factor assumptions, used in their analysis based on historical claim experience and independently calculated a range of reasonable reserve estimates for comparison to management's best estimate of the liability for incurred but not paid claims. Additionally, we performed a review of the prior period liabilities for incurred but not paid claims to subsequent claims development.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 1944.

Indianapolis, Indiana
February 20, 2025

Elevance Health, Inc.
Consolidated Balance Sheets

	December 31, 2024	December 31, 2023
(In millions, except share data)		
Assets		
Current assets:		
Cash and cash equivalents	$ 8,288	$ 6,526
Fixed maturity securities (amortized cost of $25,879 and $30,446; allowance for credit losses of $6 and $4)	25,201	29,614
Equity securities	1,192	229
Premium receivables	8,011	7,902
Self-funded receivables	5,044	4,558
Other receivables	6,016	5,405
Other current assets	4,700	5,795
Assets held for sale	490	—
Total current assets	58,942	60,029
Long-term investments:		
Fixed maturity securities (amortized cost of $1,049 and $890; allowance for credit losses of $0 and $0)	1,035	876
Other invested assets	9,749	6,107
Property and equipment, net	4,652	4,359
Goodwill	28,277	25,317
Other intangible assets	12,094	10,273
Other noncurrent assets	2,140	1,967
Total assets	$ 116,889	$ 108,928
Liabilities and equity		
Liabilities		
Current liabilities:		
Medical claims payable	$ 15,746	$ 16,111
Other policyholder liabilities	4,204	5,600
Unearned income	1,508	1,402
Accounts payable and accrued expenses	6,927	6,910
Short-term borrowings	365	225
Current portion of long-term debt	1,649	1,649
Other current liabilities	10,029	9,894
Liabilities held for sale	153	—
Total current liabilities	40,581	41,791
Long-term debt, less current portion	29,218	23,246
Reserves for future policy benefits	190	778
Deferred tax liabilities, net	2,148	1,970
Other noncurrent liabilities	3,326	1,738
Total liabilities	75,463	69,523
Commitments and Contingencies—Note 14		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 227,479,695 and 233,071,088	2	2
Additional paid-in capital	8,911	8,868
Retained earnings	33,549	31,749
Accumulated other comprehensive loss	(1,147)	(1,313)
Total shareholders' equity	41,315	39,306
Noncontrolling interests	111	99
Total equity	41,426	39,405
Total liabilities and equity	$ 116,889	$ 108,928

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Income

(In millions, except per share data)	Years Ended December 31 2024	2023	2022
Revenues			
Premiums	$ 144,166	$ 142,854	$ 133,229
Product revenue	22,630	19,452	14,978
Service fees	8,408	7,903	7,453
Total operating revenue	175,204	170,209	155,660
Net investment income	2,051	1,825	1,485
Net losses on financial instruments	(445)	(694)	(550)
Gain on sale of business	201	—	—
Total revenues	177,011	171,340	156,595
Expenses			
Benefit expense	127,567	124,330	116,642
Cost of products sold	19,750	17,293	13,035
Operating expense	20,025	20,087	17,700
Interest expense	1,185	1,030	851
Amortization of other intangible assets	580	885	767
Total expenses	169,107	163,625	148,995
Income before income tax expense	7,904	7,715	7,600
Income tax expense	1,933	1,724	1,712
Net income	5,971	5,991	5,888
Net loss (gain) attributable to noncontrolling interests	9	(4)	6
Shareholders' net income	$ 5,980	$ 5,987	$ 5,894
Shareholders' earnings per share			
Basic	$ 25.81	$ 25.38	$ 24.56
Diluted	$ 25.68	$ 25.22	$ 24.28

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Comprehensive Income

(In millions)	Years Ended December 31 2024	2023	2022
Net income	$ 5,971	$ 5,991	$ 5,888
Other comprehensive income (loss), net of tax:			
Change in net unrealized gains/losses on investments	103	1,117	(2,260)
Change in non-credit component of impairment losses on investments	1	—	(3)
Change in net unrealized gains/losses on cash flow hedges	4	18	10
Change in net periodic pension and other benefit costs	60	40	(70)
Change in future policy benefits	(2)	(3)	32
Foreign currency translation adjustments	(6)	(1)	(13)
Other comprehensive income (loss)	160	1,171	(2,304)
Net loss (gain) attributable to noncontrolling interests	9	(4)	6
Other comprehensive loss attributable to noncontrolling interests	6	6	11
Total shareholders' comprehensive income	$ 6,146	$ 7,164	$ 3,601

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Cash Flows

(In millions)	Years Ended December 31 2024	2023	2022
Operating activities			
Net income	$ 5,971	$ 5,991	$ 5,888
Adjustments to reconcile net income to net cash provided by operating activities:			
Net losses on financial instruments	445	694	550
Gain on sale of business	(201)	—	—
Equity in net earnings (losses) of other invested assets	(1)	33	(293)
Depreciation and amortization	1,393	1,745	1,675
Deferred income taxes	(374)	(602)	(115)
Impairment of property, equipment and right-of-use assets	103	446	7
Share-based compensation	191	289	264
Changes in operating assets and liabilities:			
Receivables, net	(683)	(1,762)	(2,510)
Other invested assets	(78)	(79)	11
Other assets	824	(675)	133
Policy liabilities	(1,840)	147	2,411
Unearned income	(113)	290	(42)
Accounts payable and other liabilities	(272)	1,640	824
Income taxes	404	(103)	(338)
Other, net	39	7	(66)
Net cash provided by operating activities	5,808	8,061	8,399
Investing activities			
Purchases of investments	(17,986)	(16,236)	(24,946)
Proceeds from sale of investments	16,547	10,596	11,988
Maturities, calls and redemptions from investments	2,025	2,940	10,620
Changes in securities lending collateral	73	78	(301)
Purchases of subsidiaries, net of cash acquired	(4,809)	(1,552)	(649)
Proceeds from sales of subsidiaries, net of cash sold	363	—	—
Purchases of property and equipment	(1,256)	(1,296)	(1,152)
Other, net	(124)	(102)	(120)
Net cash used in investing activities	(5,167)	(5,572)	(4,560)
Financing activities			
Proceeds from long-term borrowings	7,710	2,574	3,071
Repayments of long-term borrowings	(1,650)	(1,909)	(1,899)
Proceeds from short-term borrowings	275	225	1,365
Repayments of short-term borrowings	(135)	(265)	(1,675)
Changes in securities lending payable	(75)	(77)	302
Changes in bank overdrafts	(638)	114	933
Repurchase and retirement of common stock	(2,900)	(2,676)	(2,316)
Cash dividends	(1,508)	(1,395)	(1,229)
Proceeds from issuance of common stock under employee stock plans	221	152	182
Taxes paid through withholding of common stock under employee stock plans	(109)	(99)	(93)
Other, net	2	7	41
Net cash provided by (used in) financing activities	1,193	(3,349)	(1,318)
Effect of foreign exchange rates on cash and cash equivalents	(6)	(1)	(14)
Change in cash and cash equivalents	1,828	(861)	2,507
Cash and cash equivalents at beginning of year	6,526	7,387	4,880
Less cash and cash equivalents included in assets held for sale at end of year	(66)	—	—
Cash and cash equivalents at end of year	$ 8,288	$ 6,526	$ 7,387

See accompanying notes.

Elevance Health, Inc.
Consolidated Statements of Shareholders' Equity

(In millions)	Total Shareholders' Equity						
	Common Stock		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income	Noncontrolling Interests	Total Equity
	Number of Shares	Par Value					
January 1, 2022	241.8	$ 2	$ 9,148	$ 27,119	$ (197)	$ 68	$ 36,140
Net income (loss)	—	—	—	5,894	—	(6)	5,888
Other comprehensive loss	—	—	—	—	(2,293)	(11)	(2,304)
Noncontrolling interests adjustment	—	—	—	—	—	36	36
Repurchase and retirement of common stock	(4.8)	—	(184)	(2,132)	—	—	(2,316)
Dividends and dividend equivalents	—	—	—	(1,234)	—	—	(1,234)
Issuance of common stock under employee stock plans, net of related tax benefits	1.0	—	352	—	—	—	352
Convertible debenture repurchases and conversions		—	(232)	—	—	—	(232)
December 31, 2022	238.0	2	9,084	29,647	(2,490)	87	36,330
Net income	—	—	—	5,987	—	4	5,991
Other comprehensive income (loss)	—	—	—	—	1,177	(6)	1,171
Noncontrolling interests adjustment	—	—	—	—	—	14	14
Repurchase and retirement of common stock, including excise tax	(5.8)	—	(217)	(2,481)	—	—	(2,698)
Dividends and dividend equivalents	—	—	—	(1,404)	—	—	(1,404)
Issuance of common stock under employee stock plans, net of related tax benefits	0.9	—	342	—	—	—	342
Convertible debenture repurchases and conversions	—	—	(341)	—	—	—	(341)
December 31, 2023	233.1	2.0	8,868.0	31,749.0	(1,313.0)	99.0	39,405.0
Net income (loss)	—	—	—	5,980	—	(9)	5,971
Other comprehensive income (loss)	—	—	—	—	166	(6)	160
Noncontrolling interests adjustment	—	—	—	—	—	27	27
Repurchase and retirement of common stock, including excise tax	(6.7)	—	(262)	(2,662)	—	—	(2,924)
Dividends and dividend equivalents	—	—	—	(1,518)	—	—	(1,518)
Issuance of common stock under employee stock plans, net of related tax benefits	1.1	—	305	—	—	—	305
December 31, 2024	227.5	$ 2	$ 8,911	$ 33,549	$ (1,147)	$ 111	$ 41,426

See accompanying notes.

Elevance Health, Inc.

Notes to Consolidated Financial Statements

December 31, 2024

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

1. Organization

References to the terms "we," "our," "us" or "Elevance Health" used throughout these Notes to Consolidated Financial Statements refer to Elevance Health, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries. References to the "states" include the District of Columbia and Puerto Rico, unless the context otherwise requires.

Elevance Health is a health company with the purpose of improving the health of humanity. We are one of the largest health insurers in the United States in terms of medical membership, serving approximately 45.7 million medical members through our affiliated health plans as of December 31, 2024. We offer a broad spectrum of network-based managed care risk-based plans to Individual, Employer Group, Medicaid and Medicare markets. In addition, we provide a broad array of managed care services to fee-based customers, including claims processing, stop loss insurance, provider network access, medical management, care management, wellness programs, actuarial services and other administrative services. We provide services to the federal government in connection with our Federal Health Products & Services business, which administers the Federal Employee Program® ("FEP®"). We provide an array of specialty services both to customers of our subsidiary health plans and to unaffiliated health plans, including pharmacy services, stop loss insurance, dental, vision and supplemental health insurance benefits, as well as integrated health services.

We are an independent licensee of the Blue Cross and Blue Shield Association ("BCBSA"), an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield ("BCBS") licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross and Anthem Blue Cross and Blue Shield. We also conduct business through arrangements with other BCBS licensees as well as other strategic partners. In addition, we serve members in numerous states as Wellpoint, Carelon, MMM and/or Simply Healthcare. We are licensed to conduct insurance operations in all 50 states, the District of Columbia and Puerto Rico through our subsidiaries.

We have organized our brand portfolio into the following core go-to-market brands:

- Anthem Blue Cross/Anthem Blue Cross and Blue Shield — represents our Anthem-branded and affiliated Blue Cross and/or Blue Shield licensed plans;
- Wellpoint — unites select non-BCBSA licensed Medicare, Medicaid and commercial plans under the Wellpoint name; and
- Carelon — this brand brings together our healthcare related services and capabilities, including our CarelonRx and Carelon Services businesses, under a single brand name.

We report our results of operations in the following four reportable segments: Health Benefits, CarelonRx, Carelon Services and Corporate & Other (our businesses that do not individually meet the quantitative thresholds for an operating segment, as well as corporate expenses not allocated to our other reportable segments). For additional discussion, see Note 20, "Segment Information."

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying consolidated financial statements include the accounts of Elevance Health and its subsidiaries and have been prepared in conformity with U.S. generally accepted accounting principles ("GAAP"). All significant intercompany accounts and transactions have been eliminated in consolidation. Our consolidated financial

statements include the accounts of Elevance Health, Inc. and subsidiaries that we control, including variable interest entities for which we are the primary beneficiary. We are considered the primary beneficiary if we have the power to direct the variable interest entity's most significant economic activities, and we have the right to receive benefits or obligations to absorb losses that could be significant to the entity. We evaluate the following criteria: (1) the structure and purpose of the entity; (2) the risks and rewards created by and shared through the entity; and (3) our ability to direct its activities, receive its benefits and absorb its losses relative to the other parties involved with the entity.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar ("USD"). We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in "Foreign currency translation adjustments" in our consolidated statements of comprehensive income.

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

Use of Estimates: The preparation of consolidated financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. Our most significant estimate relates to estimates and judgments for medical claims payable. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash and cash equivalents includes available cash and all highly liquid investments with maturities of three months or less when purchased. We control a number of bank accounts that are used exclusively to hold customer funds for the administration of customer benefits, and we have cash and cash equivalents on deposit to meet certain regulatory requirements. These amounts totaled $409 and $294 at December 31, 2024 and 2023, respectively, and are included in the cash and cash equivalents line on our consolidated balance sheets.

Investments: We classify fixed maturity securities in our investment portfolio as "available-for-sale" and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, we write down the fixed maturity security's cost basis to fair value and record an impairment loss in our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or if it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, we recognize the credit component of the impairment as an allowance for credit loss in our consolidated balance sheets and record an impairment loss in our consolidated statements of income. The non-credit component of the impairment is recognized in accumulated other comprehensive loss. Furthermore, unrealized losses entirely caused by non-credit-related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive loss.

The credit component of an impairment is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of purchase. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral, including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings and estimates regarding timing and amount of recoveries associated with a default.

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the purchase date of the securities. Such adjustments are reported within net investment income.

The changes in fair value of our marketable equity securities are recognized in our results of operations within net gains and losses on financial instruments. Certain marketable equity securities are held to satisfy contractual obligations and are reported under the caption “Other invested assets” in our consolidated balance sheets.

Mortgage loans on real estate are classified as held for investment and are reported at their amortized cost basis net of loss allowance under the caption “Other invested assets” in our consolidated balance sheets. Amortized cost is the amount at which the loan is originated, adjusted for accrued interest, amortization of premium, discount and net deferred fees or costs, collection of cash and write-offs.

We have corporate-owned life insurance policies on certain participants in our deferred compensation plans and other members of management. The cash surrender value of the corporate-owned life insurance policies is reported under the caption “Other invested assets” in our consolidated balance sheets.

We have investments in limited partnerships (“LPs”) and companies in which our ownership interest may enable us to influence the operating or financial decisions of the investee company, including unconsolidated variable interest entities. These investments are accounted for using the equity method of accounting and are reported within “Other invested assets” in our consolidated balance sheets. Our proportionate share of equity in net income for these LPs and unconsolidated investee companies is reported within “Net investment income” in our consolidated statements of income. The carrying value of these investments are written down, or impaired, to fair value when a decline in value is considered to be other-than temporary. In applying the equity method (including assessment for other-than temporary impairment), we use financial information provided by the LPs and investee companies, generally on a one-to three-month lag. We consolidate investee companies in certain other instances where it is deemed to exercise control, or is considered the primary beneficiary of a variable interest entity.

Investment income is recorded when earned. All securities sold resulting in investment realized gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. Under Financial Accounting Standards Board (“FASB”) guidance related to accounting for transfers and servicing of financial assets and extinguishments of liabilities, we recognize the collateral as an asset, which is reported in Other current assets on our consolidated balance sheets, and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported in Other current liabilities. The securities on loan are reported in the applicable investment category on our consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive income as a separate component of shareholders’ equity. The market value of loaned securities and that of the collateral pledged can fluctuate in non-synchronized fashions. To the extent the loaned securities’ value appreciates faster or depreciates slower than the value of the collateral pledged, we are exposed to the risk of the shortfall. As a primary mitigating mechanism, the loaned securities and collateral pledged are marked to market on a daily basis and the shortfall, if any, is collected accordingly. Secondarily, the collateral level is set at 102% of the value of the loaned securities, which provides a cushion before any shortfall arises. The investment of the cash collateral is subject to market risk, which is managed by limiting the investments to higher quality and shorter duration instruments.

Receivables: Receivables are reported net of amounts for expected credit losses. The allowance for doubtful accounts is based on historical collection trends, future forecasts and our judgment regarding the ability to collect specific accounts.

Premium receivables include the uncollected amounts from insured groups, individuals and government programs. Premium receivables are reported net of an allowance for doubtful accounts of $183 and $212 at December 31, 2024 and 2023, respectively.

Self-funded receivables include administrative fees, claims and other amounts due from fee-based customers. Self-funded receivables are reported net of an allowance for doubtful accounts of $115 and $87 at December 31, 2024 and 2023, respectively.

Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance receivables, proceeds due from brokers on investment trades that have not yet settled, accrued investment income and other miscellaneous amounts due

to us. These receivables are reported net of an allowance for doubtful accounts of $1,385 and $941 at December 31, 2024 and 2023, respectively.

Income Taxes: We file a consolidated U.S. federal income tax return. Deferred income tax assets and liabilities are recognized for temporary differences between the financial statement and tax return basis of assets and liabilities based on enacted tax rates and laws and are reported net on our consolidated balance sheets. The deferred tax benefits of the deferred tax assets are recognized to the extent realization of such benefits is more likely than not. Deferred income tax expense or benefit generally represents the net change in deferred income tax assets and liabilities during the year, excluding the impact from amounts initially recorded for business combinations, if any, and amounts recorded to accumulated other comprehensive income. Current income tax expense represents the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

The Internal Revenue Code subjects a U.S. shareholder to tax on Global Intangible Low-Taxed Income ("GILTI") earned by certain foreign subsidiaries. We have elected to account for GILTI tax in the year the tax is incurred.

The Inflation Reduction Act of 2022 includes a provision that imposes a new corporate alternative minimum tax (the "Corporate AMT") that became effective for us beginning January 1, 2023. We have elected to account for the effects of the Corporate AMT on deferred tax assets and carryforwards and tax credits in the period they arise. We have also elected to disregard Corporate AMT when evaluating the need for a valuation allowance for non-Corporate AMT deferred tax assets. We do not believe the Corporate AMT will have a material impact on our consolidated financial position, results of operations, cash flows or related disclosures. Additionally, the Inflation Reduction Act of 2022 imposes an excise tax on the fair market value of net stock repurchases made after December 31, 2022. These are included as a charge to retained earnings as a component of the repurchase and retirement of common stock.

We account for income tax contingencies in accordance with FASB guidance that contains a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold, which all income tax positions must achieve before being recognized in the financial statements.

Property and Equipment: Property and equipment is recorded at cost, net of accumulated depreciation. Depreciation is computed principally by the straight-line method over estimated useful lives ranging from fifteen to thirty years for buildings and improvements, three to five years for computer equipment and software, and seven years for furniture and other equipment. Leasehold improvements are depreciated over the term of the related lease. Certain costs related to the development or purchase of internal-use software are capitalized and amortized over estimated useful lives ranging from three to ten years.

Goodwill and Other Intangible Assets: FASB guidance requires business combinations to be accounted for using the acquisition method of accounting, and it also specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Goodwill represents the excess of the cost of acquisition over the fair value of net assets acquired, including other intangible assets. Other intangible assets represent the values assigned to customer relationships, provider and hospital networks, Blue Cross and Blue Shield and other trademarks, licenses and other agreements, such as non-compete agreements. Goodwill and other intangible assets are allocated to reportable segments based on the relative fair value of the components of the businesses acquired.

Goodwill and other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually. Goodwill and other intangible assets are allocated to reporting units for purposes of the annual goodwill impairment test. Other intangible assets with indefinite lives, such as trademarks, are tested for impairment separately. We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets with indefinite lives. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur.

FASB guidance allows for qualitative assessments of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for purposes of a goodwill impairment analysis and whether it is more likely than not that an indefinite-lived intangible asset is impaired for purposes of an indefinite-lived intangible asset impairment analysis. Estimated fair values developed based on our assumptions and judgments might be different if other reasonable assumptions and estimates were to be used. Qualitative analysis involves assessing situations and developments that could affect key

drivers used to evaluate whether the fair value of our goodwill and indefinite-lived intangible assets is impaired. Our procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors, and entity specific events.

Quantitative analysis must be performed if qualitative analyses are not conclusive. Entities also have the option to bypass the assessment of qualitative factors and proceed directly to performing quantitative analyses. Fair value for purposes of a quantitative goodwill impairment test is calculated using a blend of the projected income and market valuation approaches. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. Our assumed discount rate is based on our industry's weighted-average cost of capital and reflects volatility associated with the cost of equity capital. Market valuations include market comparisons to publicly traded companies in our industry and are based on observed multiples of certain measures including revenue; earnings before interest, taxes, depreciation and amortization ("EBITDA"); and book value of invested capital.

A goodwill impairment loss is recognized to the extent that the carrying amount exceeds the asset's estimated fair value. This determination consists of a one-step test comparing the estimated fair value of a reporting unit, including goodwill, to its carrying amount. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized. This goodwill impairment loss is equal to the excess of the reporting unit's carrying amount over its estimated fair value, which is recorded in the results of operations.

Fair value for purposes of a quantitative impairment test for indefinite-lived intangible assets is estimated using a projected income approach. We recognize an impairment loss when the estimated fair value of indefinite-lived intangible assets is less than the carrying value, which is recorded in the results of operations. If significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Derivative Financial Instruments: We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, collars, swaptions, embedded derivatives and warrants. Derivatives embedded within non-derivative instruments, such as options embedded in convertible fixed maturity securities, are bifurcated from the host instrument when the embedded derivative is not clearly and closely related to the host instrument. Our use of derivatives is limited by statutes and regulations promulgated by the various regulatory bodies to which we are subject, and by our own derivative policy. Our derivative use is generally limited to hedging purposes, on an economic basis, and we generally do not use derivative instruments for speculative purposes.

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through active portfolio management, including rebalancing our existing portfolios of assets and liabilities, as well as changing the characteristics of investments to be purchased or sold in the future. In addition, derivative financial instruments are used to modify the interest rate exposure of certain liabilities or forecasted transactions. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge, on an economic basis, interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

All investments in derivatives are recorded as assets or liabilities at fair value, except certain put and call options on large blocks of equity securities. Put and call options on large blocks of equity securities are initially recorded at fair value; however, they are not subsequently marked to market. If certain correlation, hedge effectiveness and risk reduction criteria are met, a derivative may be specifically designated as a hedge of exposure to changes in fair value or cash flow. The accounting for changes in the fair value of a derivative depends on the intended use of the derivative and the nature of any hedge designation thereon. Amounts excluded from the assessment of hedge effectiveness, if any, are reported in results of operations immediately. If the derivative is not designated as a hedge, the gain or loss resulting from the change in the fair value of the derivative is recognized in results of operations in the period of change. Cash flows associated with the settlement of non-designated derivatives are shown on a net basis in investing activity in our consolidated statements of cash flow.

From time to time, we may also purchase derivatives to hedge, on an economic basis, our exposure to foreign currency exchange fluctuations associated with the operations of certain of our subsidiaries. We generally use futures or forward

contracts for these transactions. We generally do not designate these contracts as hedges and, accordingly, the changes in fair value of these derivatives are recognized in results of operations immediately.

As part of our international operations, we conduct transactions in foreign currencies, which exposes us to risks associated with fluctuations in foreign currency exchange rates. To manage this exposure, we utilize forward contracts to hedge expenses that are denominated in currencies other than the U.S. dollar. These forward contracts are designated as cash flow hedges and qualify for hedge accounting treatment under the applicable accounting standards.

Credit exposure associated with non-performance by the counterparties to derivative instruments is generally limited to the uncollateralized fair value of the asset related to instruments recognized in the consolidated balance sheets. We attempt to mitigate the risk of non-performance by selecting counterparties with high credit ratings and monitoring their creditworthiness and by diversifying derivatives among multiple counterparties. At December 31, 2024, we believe there were no material concentrations of credit risk with any individual counterparty.

We generally enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions with the same counterparty. Certain of our derivative agreements also contain credit support provisions that require us or the counterparty to post collateral if there are declines in the derivative fair value or our credit rating. The derivative assets and derivative liabilities are reported at their fair values net of collateral and netting by the counterparty.

Retirement Benefits: We recognize the funded status of pension and other postretirement benefit plans on the consolidated balance sheets based on fiscal-year-end measurements of plan assets and benefit obligations. Prepaid pension benefits represent prepaid costs related to defined benefit pension plans and are reported with other noncurrent assets. Prepaid postretirement benefits represent prepaid costs related to retiree medical, life, vision and dental benefits and are reported with other noncurrent assets.

We determine the expected return on plan assets using the calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of net periodic benefit cost.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. We use the annual spot rate approach for setting our discount rate. Under the spot rate approach, individual spot rates from a full yield curve of published rates are used to discount each plan’s cash flows to determine the plan’s obligations.

The assumed healthcare cost trend rates used to measure the expected cost of other postretirement benefits are based on an initial assumed healthcare cost trend rate declining to an ultimate healthcare cost trend rate over a select number of years.

Medical Claims Payable: Liabilities for medical claims payable include estimated provisions for incurred but not paid claims on an undiscounted basis, as well as estimated provisions for expenses related to the processing of claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported; (2) claims reported to us but not yet processed through our systems; and (3) claims reported to us and processed through our systems but not yet paid.

Liabilities for claims incurred but not reported and reported but not yet processed through our systems are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Our reserving practice for claim liabilities is to consistently recognize the appropriate amount of reserve within a level of confidence required by Actuarial Standards of Practice. We determine the amount of the liability for incurred but not yet reported or processed claims by following a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into “claim triangles,” which compare claim incurred dates to the dates of claim payments. This information is analyzed to create “completion factors” that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are projected by estimating the claims expense for those months based on recent claims expense levels and healthcare trend levels ("trend factors").

On a regular basis, we review cost trends and utilization assumptions set upon initial establishment of claim liabilities. We utilize subsequent paid claims activity to monitor and continuously adjust the claims liability and benefit expense. If actual results are determined to be materially different than assumptions regarding cost trends and utilization, future periods of our income statement and overall financial position could be impacted.

Premium deficiencies are recognized when it is probable that expected claims plus administrative expenses will exceed future premiums on existing medical insurance contracts without consideration of investment income. For purposes of evaluating premium deficiencies, contracts are deemed to be either short or long duration and are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. Once established, reserves for premium deficiencies are released commensurate with actual claims experience over the remaining life of the contract. No reserves for premium deficiencies were established at December 31, 2024 or 2023.

Benefit expense includes incurred medical claims as well as quality improvement expenses for our risk-based members. Quality improvement activities are those designed to improve member health outcomes, prevent hospital readmissions and improve patient safety. They also include expenses for wellness and health promotion provided to our members.

Other Policyholder Liabilities: Other policyholder liabilities include rate stabilization reserves associated with retrospectively rated insurance contracts and certain case-specific reserves. Rate stabilization reserves represent accumulated premiums that exceed what customers owe us based on actual claim experience. The timing of payment of these retrospectively rated refunds is based on the contractual terms with our customers and can vary from period to period based on the specific contractual requirements.

Other policyholder liabilities also include liabilities for premium refunds based upon the minimum medical loss ratio ("MLR"). We are required to meet certain minimum MLR thresholds prescribed by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended (collectively, the "ACA"). If we do not meet or exceed the minimum MLR thresholds specified by the ACA, we are required to pay rebates to certain customers. Minimum MLR rebates are calculated by subsidiary, state and applicable line of business in accordance with regulations issued by the US Department of Health and Human Services ("HHS"). Such calculations are made using estimated calendar year medical loss expense and premiums, as defined by HHS.

We follow HHS guidelines for determining the types of expenses that may be included in our minimum MLR rebate calculations, which differ from benefit expense and premiums as reported in our consolidated financial statements prepared in conformity with GAAP. Certain amounts reported as expense in our consolidated GAAP financial statements may be reported as a reduction of premiums in accordance with HHS regulations. In addition, profit amounts included in our payments to third-party administrative service providers are recorded as benefit expense in our consolidated GAAP financial statements, while HHS does not allow for the inclusion of these expenses within the medical loss expense for purposes of calculating minimum MLR.

Also included are our risk-adjustment payables for certain risk-adjustment programs. The risk-adjustment programs reallocate funds from insurers with lower risk populations to insurers with higher risk populations based on the relative risk scores of participants. We estimate our payable based on the risk of our customers compared to the risk of other customers in the same state and market, considering data obtained from industry studies and HHS. Payables are recorded as adjustments to premium revenue based on our year-to-date experience when the amounts are reasonably estimable and collection is reasonably assured. Final revenue adjustments are determined by HHS in the year following the policy year.

Reserves for Future Policy Benefits: Future policy benefits include liabilities for insurance policies for which some of the premiums received in earlier years are intended to pay anticipated benefits to be incurred in future years. Future policy benefits are continually monitored and reviewed, and when reserves are adjusted, differences are reflected in benefit expense.

We believe that our liabilities for future policy benefits, along with future premiums received, are adequate to satisfy our ultimate benefit liability; however, these estimates are inherently subject to a number of variable circumstances. Consequently, the actual results could differ materially from the amounts recorded in our consolidated financial statements.

Revenue Recognition: Premiums for risk-based contracts are recognized as revenue over the period insurance coverage is provided, and, if applicable, net of amounts recognized for MLR rebates, risk adjustment, reinsurance and risk corridor under contractual premium stabilization arrangements, the ACA or other regulatory requirements. Premiums may also include performance incentives and penalties, which are recognized based on contractual terms. We estimate amounts receivable and payable under these contractual terms, and to the extent that such estimated amounts vary from the final amounts paid, the adjustments are included in earnings in the period of final settlement. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Premium payments related to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheets as Unearned income. Premiums include revenue adjustments for retrospectively rated contracts where revenue is based on the estimated loss experience of the contract. Premium rates for certain lines of business are subject to approval by the Department of Insurance of each respective state. Additionally, delays in annual premium rate changes from contracted government agencies require that we defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized depending on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Service fees include revenue from certain group contracts that provide for the group to be at risk for all, or with supplemental insurance arrangements, a portion, of their claims experience. We charge these fee-based groups an administrative fee, which is based on the number of members in a group and the group's claim experience. In addition, service fees include amounts received for the administration of Medicare, certain other government programs, and administrative services arrangements of our Carelon subsidiaries. Generally, each fee-based arrangement includes services which constitute a single suite of services provided and for which consideration is based upon an agreed-upon rate, regardless of the amount of services provided in a given period. As with premiums, each fee-based arrangement may include terms with retroactive rate or membership adjustments, performance incentives and penalties, each of which is a form of variable consideration within the transaction price. As such, each fee-based arrangement contains a single performance obligation that constitutes a series, and revenue is recognized over time as the services are performed. All benefit payments under these programs are excluded from benefit expense.

The determination of whether services are distinct performance obligations that should be accounted for separately or combined as one unit of accounting may require significant judgment. The estimation of variable consideration to be recognized requires significant judgment in the determination of the level of achievement of performance incentives, service level achievements subject to performance penalties, and the completion level of tasks subject to implementation fees.

Product revenue represents services performed by CarelonRx for unaffiliated pharmacy customers and includes ingredient costs (net of any rebates or discounts), including co-payments made by or on behalf of the customer, and service fees. Unaffiliated pharmacy customers include our fee-based groups that have contracted with CarelonRx for pharmacy services and third-party health plans. Product revenues and costs of goods sold for our affiliated health plans are eliminated in consolidation, excluding co-payments and subsidies made by or on behalf of affiliated customers. Product revenue for pharmacy services is recognized using the gross method at the negotiated contract price when CarelonRx has concluded that it is the principal, and it controls the services before prescription drugs are transferred to the customer. CarelonRx determined it is the principal due to its contractual rights to design and develop a listing of prescription drugs offered to the customer (formulary management); its control over establishing the pharmacy network available to the customer to have its prescription fulfilled (network management); and its discretion over establishing the pricing for prescription drugs. Overall, control over these activities indicate CarelonRx is primarily responsible for fulfilling the promise to provide pharmacy services. CarelonRx recognizes revenue when control of the prescription drugs is transferred to customers, in an amount it expects to be entitled to in exchange for the products or services provided.

For our non-risk-based contracts, we had no material contract assets, contract liabilities or deferred contract costs recorded on our consolidated balance sheets at December 31, 2024 and 2023. Revenue recognized in 2024 and 2023 from performance obligations related to prior years, such as due to changes in transaction price, was not material. For contracts that

have an original expected duration of greater than one year, revenue expected to be recognized in future periods related to unfulfilled contractual performance obligations and contracts with variable consideration related to undelivered performance obligations is not material.

Cost of Products Sold: CarelonRx's cost of products sold includes the cost of prescription drugs dispensed to unaffiliated pharmacy customers (net of rebates or discounts). Cost of products sold includes per-claim administrative fees for prescription fulfillment by its vendor and certain CarelonRx direct costs related to sales and administration of customer contracts.

Share-Based Compensation: Our current compensation philosophy provides for share-based compensation, including stock options, restricted stock awards and an employee stock purchase plan. Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the date of the grant. Restricted stock awards are issued at the fair value of the stock on the grant date. The employee stock purchase plan allows for a purchase price per share which is 90% of the fair value of a share of common stock on the lower of the first or last trading day of the plan quarter. The employee stock purchase plan discount is recognized as compensation expense based on GAAP guidance. All other share-based payments to employees are recognized as compensation expense in our consolidated statements of income based on their fair values. Additionally, excess tax benefits, which result from actual tax benefits realized when awards vest or options are exercised exceeding deferred tax benefits previously recognized based on grant date fair value, are recognized as tax benefits in the consolidated statements of income.

***Advertising and Marketing Costs*:** We use print, broadcast and other advertising to promote our products and to develop our corporate image. We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Employer Group risk-based customers with a smaller employee base. Products for our Employer Group risk-based customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer who work with industry specialists from our in-house sales force. In the Individual and Group markets, we offer products through state or federally facilitated marketplaces, or Public Exchanges, and off-exchange products. The cost of advertising and marketing for product promotion is expensed as incurred, while advertising and marketing costs associated with our corporate image are expensed when first aired. Total advertising and marketing expense was $540, $599 and $511 for the years ended December 31, 2024, 2023 and 2022, respectively.

Leases: We lease office space and certain computer and related equipment under noncancelable operating leases. We determine whether an arrangement is or contains a lease at its inception. We recognize lease liabilities based on the present value of the minimum lease payments not yet paid by using the lease term, any amounts probable of being owed under any residual value guarantees and the discount rate determined at lease commencement. As our leases do not generally provide an implicit rate, we use our incremental secured borrowing rate commensurate with the underlying lease terms to determine the present value of our lease payments. Our lease liabilities may include amounts for options to extend or terminate a lease when it is reasonably certain that we will exercise that option. We recognize operating right-of-use ("ROU") assets at an amount equal to the lease liability adjusted for prepaid or accrued rent, the remaining balance of any lease incentives and unamortized initial direct costs.

The operating lease liabilities are reported in Other current liabilities and Other noncurrent liabilities and the related ROU assets are reported in Other noncurrent assets on our consolidated balance sheets. Lease expense for our operating leases is calculated on a straight-line basis over the lease term and is reported in operating expense on our consolidated statements of income. For our office space leases, we account for the lease and non-lease components (such as common area maintenance) as a single lease component. We also do not recognize a lease liability or ROU asset for our office space leases whose lease terms, at commencement, are twelve months or less and that do not include a purchase option or option to extend that we are reasonably certain to exercise.

We assess our ROU assets for impairment when there are indicators of impairment and compare the carrying amount of the ROU asset to its estimated undiscounted future cash flows. If the estimated undiscounted future cash flows are less than the carrying amount of the ROU asset, an impairment calculation is performed. An impairment loss is recorded for the difference of the ROU asset's carrying value that exceeds its estimated discounted cash flows. During the years ended December 31, 2024, 2023 and 2022, we recorded $17, $23 and $34, respectively, for impairment and abandonment of ROU assets. See Note 18, "Leases," for additional information about the ROU asset impairment and abandonment charges.

Shareholders' Earnings per Share: Earnings per share amounts, on a basic and diluted basis, have been calculated based upon the weighted-average common shares outstanding for the period.

Basic shareholders' earnings per share excludes dilution and is computed by dividing income available to common shareholders by the weighted-average number of common shares outstanding for the period. Diluted shareholders' earnings per share may include the dilutive effect of stock options, restricted stock and convertible debentures, using the treasury stock method. The treasury stock method assumes exercise of stock options and vesting of restricted stock, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and the number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Guidance: In November 2023, the FASB issued Accounting Standards Update No. 2023-07, *Segment Reporting (Topic 280): Improvements to Reportable Segment Disclosures* ("ASU 2023-07"). The amendments in ASU 2023-07 are intended to improve reportable segment disclosure requirements, primarily through enhanced disclosures about significant segment expenses. ASU 2023-07 is effective for our fiscal year beginning after December 15, 2023, and interim periods within our fiscal year beginning after December 15, 2024. The amendments are to be applied retrospectively to all prior periods presented in the financial statements, and upon transition, the significant segment expense categories and amounts disclosed in the prior periods should be based on the significant segment expense categories identified and disclosed in the period of adoption. The adoption of ASU 2023-07 did not have an impact on our results of operations or our consolidated cash flows.

In November 2020, the FASB issued Accounting Standards Update No. 2020-11, *Financial Services—Insurance (Topic 944): Effective Date and Early Application* ("ASU 2020-11"). The amendments in ASU 2020-11 changed the effective date and early application of Accounting Standards Update No. 2018-12, *Financial Services—Insurance (Topic 944): Targeted Improvements to the Accounting for Long-Duration Contracts*, which was issued in November 2018. The amendments in ASU 2020-11 extended the original effective date by one year to our interim and annual reporting periods beginning after December 15, 2022. This standard requires us to review cash flow assumptions for our long-duration insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income. This standard also requires us to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount our reserves for future policy benefits will be based on an estimate of the yield for an upper-medium grade fixed-income instrument with a duration profile matching that of our liabilities. In addition, this standard changes the amortization method for deferred acquisition costs. We adopted these amendments on January 1, 2023, using the modified retrospective transition method for changes to the liability for future policy benefits and deferred acquisition costs as of the transition date, January 1, 2021. While the adoption did not have an overall material impact, our prior period financial statements presented in this Annual Report on Form 10-K have been restated to reflect the impacts of our adoption as required by the new standard. An adjustment of $(131) was made to shareholders' net income for the year ended December 31, 2022, which include an adjustment to benefit expense of $155. In addition, the following balance sheet adjustments were made for the year ended December 31, 2022: $(17) to total assets; $47 to total liabilities; $13 to accumulated other comprehensive loss; and $(64) to shareholders' equity and total equity.

Recent Accounting Guidance Not Yet Adopted: In November 2024, the FASB issued Accounting Standards Update No. 2024-03, *Income Statement - Reporting Comprehensive Income - Expense Disaggregation Disclosures (Subtopic 220-40): Disaggregation of Income Statement Expenses* ("ASU 2024-03"). This standard requires additional expense breakdowns in the footnotes for items such as inventory purchases, employee compensation, depreciation, and intangible asset amortization. Public companies must also provide a qualitative description of remaining expense amounts not separately disclosed, as well as the definition and total amount of selling expenses. ASU 2024-03 is effective for our fiscal year beginning after December 15, 2026, and interim periods within our fiscal year beginning after December 15, 2027. The amendments are to be applied either prospectively to financial statements issued for reporting periods after the effective date of the update, or retrospectively to all prior periods presented in the financial statements. We are currently evaluating the effects the adoption of ASU 2024-03 will have on our consolidated financial statements and related disclosures.

In December 2023, the FASB issued Accounting Standards Update No. 2023-09, *Income Taxes (Topic 740)* ("ASU 2023-09"). The amendments in ASU 2023-09 are intended to improve income tax disclosures, primarily related to the rate reconciliation and income taxes paid information. ASU 2023-09 is effective for our fiscal year beginning after December 15, 2024. The amendments are to be applied on a prospective basis, although retrospective adoption is permitted. We do not believe the adoption of ASU 2023-09 will have a material impact on our consolidated financial statements or disclosures.

In August 2023, the FASB issued Accounting Standards Update No. 2023-05, *Business Combinations—Joint Venture Formations (Subtopic 805-60): Recognition and Initial Measurement* ("ASU 2023-05"). ASU 2023-05 clarifies existing guidance to reduce diversity in practice and is requiring a joint venture to recognize and initially measure its assets and liabilities using a new basis of accounting, at fair value, upon formation. These amendments are effective prospectively for all joint venture formations with a formation date on or after January 1, 2025. We do not believe the adoption of ASU 2023-05 will have a material impact on our consolidated financial statements and disclosures.

There were no other new accounting pronouncements that were issued or became effective during the year ended December 31, 2024 that had, or are expected to have, a material impact on our financial position, results of operations, cash flows or financial statement disclosures.

3. Business Acquisitions and Divestitures

Completed Acquisitions

On December 31, 2024, we completed our acquisition of Centers Plan for Healthy Living LLC and Centers for Specialty Care Group IPA, LLC ("Centers"). Centers is a managed long-term care plan that serves New York state Medicaid and dual-eligible Medicaid/Medicare members, enabling adults with long-term care needs and disabilities to live safely and independently in their own home. This acquisition aligns with our strategic plan to grow the Health Benefits segment and leverage industry-leading expertise while serving Medicaid and dual-eligible populations. As of December 31, 2024, the purchase price was allocated to the tangible and intangible net assets acquired based on management's initial estimates of their fair values, of which $152 has been allocated to finite-lived intangible assets, $426 to indefinite-lived intangible assets and $450 to goodwill. The majority of the goodwill is not deductible for income tax purposes. As of December 31, 2024, the initial accounting for the acquisition has not been finalized. The proforma effects of this acquisition for prior periods were not material to our consolidated results of operations.

On December 10, 2024, we completed our acquisition of RSV QOZB LTSS, Inc. and certain affiliated entities ("CareBridge"), a value-based healthcare company that manages home and community-based services for Medicaid and dual-eligible members receiving long-term services and support. This acquisition aligns with Carelon Services' care at home strategy, and our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve. As of December 31, 2024, the purchase price was allocated to the tangible and intangible net assets acquired based on management's initial estimates of their fair values, of which $995 has been allocated to finite-lived intangible assets and $1,631 to goodwill. The majority of the goodwill is not deductible for income tax purposes. As of December 31, 2024, the initial accounting for the acquisition has not been finalized. The proforma effects of this acquisition for prior periods were not material to our consolidated results of operations.

On March 11, 2024, we completed our acquisition of Paragon Healthcare, Inc. ("Paragon"). Paragon, which operates as part of CarelonRx, provides infusion services and injectable therapies through its omnichannel model of ambulatory infusion centers, home infusion pharmacies, and other specialty pharmacy services. This acquisition aligns with our vision to be an innovative, valuable and inclusive healthcare partner by providing care management programs that improve the lives of the people we serve. As of December 31, 2024, the purchase price was allocated to the tangible and intangible net assets acquired based on management's initial estimates of their fair values, of which $411 has been allocated to finite-lived intangible assets and $747 to goodwill. The majority of the goodwill is not deductible for income tax purposes. As of December 31, 2024, the initial accounting for the acquisition has not been finalized. The proforma effects of this acquisition for prior periods were not

material to our consolidated results of operations.

During the year ended December 31, 2024, in total, we completed business combinations for total cash consideration of approximately $5,128. The purchase prices for all business combinations were preliminarily allocated to the tangible and intangible net assets acquired based on management's initial estimates of their fair values. Tangible net assets acquired were $(236), and intangible assets were $5,364, of which $1,872 was allocated to finite-lived intangible assets, $426 to indefinite-lived intangible assets, and $3,066 to goodwill. Of these amounts, $2,641 was allocated to our Carelon Services reportable segment, $1,594 was allocated to our CarelonRx reportable segment and $1,129 to our Health Benefits reportable segment. The majority of goodwill is not deductible for income tax purposes. As of December 31, 2024, the initial accounting for the acquisitions had not been finalized. Any subsequent adjustments made to the assets acquired or liabilities assumed during the measurement period may result from a purchase price adjustment, or will be recorded as an adjustment to goodwill and/or intangible assets acquired. The proforma effects of these acquisitions for prior periods were not material to our consolidated results of operations.

During the year ended December 31, 2023, in total, we completed business combinations for total cash consideration of approximately $1,655. These acquisitions included BioPlus Parent, LLC and its subsidiaries (“BioPlus”), which were acquired in February 2023. The purchase prices for all business combinations were preliminarily allocated to the tangible and intangible net assets acquired based on management's initial estimates of their fair values, of which $820 was allocated to finite-lived intangible assets and $923 to goodwill. Of these amounts, $1,723 was allocated to our CarelonRx reportable segment and $20 to our Carelon Services reportable segment. The majority of goodwill is not deductible for income tax purposes. As of December 31, 2024, the accounting for the acquisitions was finalized. The proforma effects of these acquisitions for prior periods were not material to our consolidated results of operations.

Acquired tangible assets (liabilities) at the acquisition date were:

	2024	2023
Cash, cash equivalents and short-term investments	$ 484	$ 6
Accounts receivable and other current assets	847	241
Property, equipment and other long-term assets	309	18
Medical claims and other policyholder liabilities payable	(154)	—
Accounts payable and other current liabilities	(1,005)	(169)
Other long-term liabilities	(242)	(1)
Deferred tax liabilities	(475)	(183)
Total net tangible assets (liabilities)	$ (236)	$ (88)

The preliminary purchase price allocations for the various 2024 business combinations are subject to adjustment as valuation analyses, primarily related to intangible assets and contingent and tax liabilities, are finalized.

Acquisition date fair values and weighted-average useful lives assigned to intangible assets include:

	2024		2023	
	Fair Value	Weighted Average Useful Life	Fair Value	Weighted Average Useful Life
Customer-related	$ 1,621	20 years	$ 796	25 years
Provider and hospital relationships	70	10 years	—	0
Other	181	8 years	24	5 years
State Medicaid licenses	426	—	—	—
Total intangible assets	$ 2,298		$ 820	

The results of operations and financial condition of acquired entities have been included in our consolidated results and the results of the corresponding operating segment as of the date of acquisition. Through December 31, 2024, the impact of

the acquired entities on revenue and net earnings was not material. Unaudited pro-forma revenues for the years ended December 31, 2024, 2023 and 2022, as if the acquisitions had occurred on January 1, 2022, were immaterial.

Divestitures

On April 1, 2024, we completed the sale of our life and disability businesses to StanCorp Financial Group, Inc. ("The Standard"), a provider of financial protection products and services for employers and individuals, which resulted in a gain on sale of business of $201 in the year ended December 31, 2024. Upon closing, we and The Standard entered into a product distribution partnership. The related net assets held for sale for the life and disability businesses divested as of December 31, 2023 and results of operations for the year ended December 31, 2024 were not material.

4. Business Optimization Initiatives

2023-2024 Business Efficiency Program

During the third quarter of 2023, based on a strategic review of our operations, assets and investments, management implemented the "2023-2024 Business Efficiency Program" to enhance operating efficiency, refine the focus of our investments and optimize our physical footprint. The 2023-2024 Business Efficiency Program included the write-off of certain information technology assets and contract exit costs, a reduction in staff including the relocation of certain job functions, and the impairment of assets associated with the closure or partial closure of data centers and offices. The 2023-2024 Business Efficiency Program was finalized as of December 31, 2024. Cash outlays associated with this program, which primarily relate to the personnel-related costs, are expected to be paid through 2025.

In 2024, we incurred $268 of costs towards the 2023-2024 Business Efficiency Program. This included primarily $72 of pre-tax charges for information technology asset write-offs, $165 of pre-tax personnel-related charges for the reduction and/or relocation of staff, which includes severance and related costs primarily determined under our existing severance plans, and $31 of pre-tax charges from asset impairments related to the closure or partial closure of offices, including operating lease-related ROU assets and other property and equipment.

In 2023, we incurred $752 of expense, which included $468 of pre-tax charges for information technology assets and contract write-offs related to projects that have been de-prioritized and stopped, $230 of pre-tax personnel-related charges for the reduction and/or relocation of workforce, which includes severance and related costs primarily determined under our existing severance plans, and $54 of pre-tax charges from asset impairments related to the closure or partial closure of data centers and offices, including operating lease-related ROU assets and other property and equipment.

These charges in both years were recognized in operating expense in the Corporate & Other segment; see Note 20, "Segment Information."

During the year ended December 31, 2024, there were $165 in charges related to employee termination costs under the 2023-2024 Business Efficiency Program, and payments were $132. During the year ended December 31, 2023, there were $230 in charges related to employee termination costs under the 2023-2024 Business Efficiency Program, and payments were $39.

5. Investments

A summary of current and long-term fixed maturity securities, available-for-sale, at December 31, 2024 and 2023 is as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Allowance For Credit Losses	Estimated Fair Value
December 31, 2024					
Fixed maturity securities:					
United States Government securities	$ 1,907	$ 2	$ (85)	$ —	$ 1,824
Government sponsored securities	156	—	(5)	—	151
Foreign government securities	19	—	(2)	—	17
States, municipalities and political subdivisions, tax-exempt	3,142	33	(123)	—	3,052
Corporate securities	14,095	192	(367)	(4)	13,916
Residential mortgage-backed securities	3,274	13	(236)	—	3,051
Commercial mortgage-backed securities	1,801	8	(60)	(1)	1,748
Other asset-backed securities	2,534	36	(92)	(1)	2,477
Total fixed maturity securities	$ 26,928	$ 284	$ (970)	$ (6)	$ 26,236
December 31, 2023					
Fixed maturity securities:					
United States Government securities	$ 1,873	$ 25	$ (54)	$ —	$ 1,844
Government sponsored securities	112	1	(3)	—	110
Foreign government securities	5	1	(2)	—	4
States, municipalities and political subdivisions, tax-exempt	3,985	69	(152)	—	3,902
Corporate securities	14,838	322	(580)	(2)	14,578
Residential mortgage-backed securities	4,071	40	(279)	—	3,832
Commercial mortgage-backed securities	2,174	13	(138)	(2)	2,047
Other asset-backed securities	4,278	25	(130)	—	4,173
Total fixed maturity securities	$ 31,336	$ 496	$ (1,338)	$ (4)	$ 30,490

Other asset-backed securities primarily consist of collateralized loan obligations and other debt securities.

For fixed maturity securities in an unrealized loss position at December 31, 2024 and 2023, the following table summarizes the aggregate fair values and gross unrealized losses by length of time those securities have continuously been in an unrealized loss position.

	Less than 12 Months			12 Months or Greater		
	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
(Securities are whole amounts)						
December 31, 2024						
Fixed maturity securities:						
United States Government securities	40	$ 1,240	$ (52)	25	$ 330	$ (33)
Government sponsored securities	10	89	(2)	36	42	(3)
Foreign government securities	2	15	(1)	2	2	(1)
States, municipalities and political subdivisions, tax-exempt	527	1,092	(22)	661	943	(101)
Corporate securities	1,415	4,717	(92)	1,317	2,645	(275)
Residential mortgage-backed securities	306	1,097	(25)	1,312	1,291	(211)
Commercial mortgage-backed securities	136	670	(15)	297	661	(45)
Other asset-backed securities	123	293	(9)	236	735	(83)
Total fixed maturity securities	2,559	$ 9,213	$ (218)	3,886	$ 6,649	$ (752)
December 31, 2023						
Fixed maturity securities:						
United States Government securities	35	$ 552	$ (9)	44	$ 370	$ (45)
Government sponsored securities	—	—	—	40	52	(3)
Foreign government securities	—	—	—	2	4	(2)
States, municipalities and political subdivisions, tax-exempt	203	354	(2)	1,034	1,811	(150)
Corporate securities	389	608	(15)	2,624	6,871	(565)
Residential mortgage-backed securities	183	438	(5)	1,620	2,075	(274)
Commercial mortgage-backed securities	112	353	(6)	534	1,317	(132)
Other asset-backed securities	110	394	(18)	761	2,342	(112)
Total fixed maturity securities	1,032	$ 2,699	$ (55)	6,659	$ 14,842	$ (1,283)

Unrealized losses on our securities shown in the table above have not been recognized into income because, as of December 31, 2024, we do not intend to sell these investments, and it is likely that we will not be required to sell these investments prior to their anticipated recovery. The declines in fair values are largely due to increasing interest rates driven by the higher rate of inflation and other market conditions.

Allowances for credit losses have been recorded in the amounts of $6 and $4 at December 31, 2024 and 2023, respectively, for declines in fair value due to unfavorable changes in the credit quality characteristics that impact our assessment of collectability of principal and interest.

The amortized cost and fair value of fixed maturity securities at December 31, 2024, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$ 198	$ 196
Due after one year through five years	4,827	4,772
Due after five years through ten years	10,550	10,378
Due after ten years	6,278	6,090
Mortgage-backed securities	5,075	4,800
Total fixed maturity securities	$ 26,928	$ 26,236

Equity Securities

A summary of current equity securities at December 31, 2024 and 2023 is as follows:

	December 31, 2024	December 31, 2023
Equity Securities:		
Exchange traded funds	$ 1,002	$ 106
Common equity securities	118	45
Private equity securities	72	78
Total	$ 1,192	$ 229

Other Invested Assets

Other invested assets include non-controlled joint ventures, including our minority interest ownership of approximately 35% of Augusta Topco Holdings, L.P. (“Mosaic Health”) and our 40% minority interest ownership of Project Freedom Holdings, LLC, which is the ultimate parent of LIBERTY Dental Plan Corporation (“Liberty Dental”).

On August 6, 2024, we made an equity investment in Mosaic Health of $2,580, consisting of cash and the net put option discussed in Note 6 “Derivative Financial Instruments”, Mosaic Health is a joint venture with Clayton, Dubilier & Rice (“CD&R”) that is designed to accelerate innovation in care delivery across multiple regions in the United States by bringing together certain care delivery and enablement assets of Carelon Management Services, LLC (“CMSI Assets”), a Carelon Health business, and two CD&R portfolio businesses, apree health and Millennium Physician Group. The investment is accounted for as an equity method investment. Our additional contribution of the CMSI Assets to Mosaic Health was completed on January 1, 2025, for which we received an additional $300 of equity (approximately 5% ownership) in Mosaic Health. The CMSI Assets are included under the captions “Assets held for sale” and “Liabilities held for sale” in our consolidated balance sheets as of December 31, 2024.

In connection with our equity method investment in Mosaic Health, we entered into a financing agreement to provide a term loan of $200 and a line of credit up to $500 to Mosaic Health. Net amounts receivable under these arrangements were $188 at December 31, 2024, which is included under the caption “Other invested assets” in our consolidated balance sheets as of December 31, 2024. During the year ended December 31, 2024, we recognized $7 in interest income from the financing arrangement with Mosaic Health. In addition to the term loan and line of credit, we committed to providing $70 of funding with no additional equity interest in Mosaic Health to meet any shortfall in operating cash flow and regulatory capital requirements of the CMSI Assets through December 31, 2026, and to fund any remaining shortfalls as necessary for which we would receive additional equity interests in Mosaic Health.

In January 2023, we made an equity investment in Liberty Dental, a joint venture with Welsh, Carson, Anderson & Stowe which engages in dental insurance and dental health care administration. The investment is accounted for as an equity method investment. In connection with our equity method investment in Liberty Dental, in December 2024 we entered into a commitment to provide funding in the form of mandatorily redeemable preferred equity shares in Liberty Dental of up to $250 of which $87 was disbursed in 2024. The mandatorily redeemable preferred equity in Liberty Dental is included in the caption "Other invested assets" in our consolidated balance sheets at December 31, 2024. Dividend income recognized from the financing arrangement during the year ended December 31, 2024 was not material.

Investment Income

The major categories of net investment income for the years ended December 31, 2024, 2023 and 2022 are as follows:

	2024	2023	2022
Fixed maturity securities	$ 1,539	$ 1,387	$ 971
Equity securities	40	18	48
Cash equivalents	235	305	77
Other invested assets	274	157	432
Investment income	2,088	1,867	1,528
Investment expenses	(37)	(42)	(43)
Net investment income	$ 2,051	$ 1,825	$ 1,485

Investment (Losses) Gains

Net investment (losses) gains for the years ended December 31, 2024, 2023 and 2022 are as follows:

	2024	2023	2022
Net gains (losses):			
Fixed maturity securities:			
Gross realized gains from sales	$ 158	$ 47	$ 52
Gross realized losses from sales	(479)	(488)	(469)
Impairment losses recognized in income	(17)	(15)	(31)
Net realized losses on fixed maturity securities	(338)	(456)	(448)
Equity securities:			
Unrealized losses recognized on equity securities still held	(6)	(1)	(78)
Net realized (losses) gains recognized on equity securities sold	(9)	6	(102)
Net (losses) gains on equity securities	(15)	5	(180)
Other investments:			
Gross gains	49	103	96
Gross losses	(25)	(63)	(64)
Impairment losses recognized in income	(126)	(291)	(34)
Net losses on other investments	(102)	(251)	(2)
Net losses on investments	$ (455)	$ (702)	$ (630)

A primary objective in the management of our fixed maturity and equity portfolios is to maximize total return relative to underlying liabilities and respective liquidity needs. In achieving this goal, assets may be sold to take advantage of market conditions or other investment opportunities as well as tax considerations. Sales will generally produce realized gains and losses. In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited

to: (i) changes in the investment environment; (ii) expectations that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

Total proceeds from sales, maturities, calls or redemptions of fixed maturity securities were $16,334, $12,289 and $22,048 for the years ended December 31, 2024, 2023 and 2022, respectively.

A significant judgment in the valuation of investments is the determination of when a credit loss has occurred. We follow a consistent and systematic process for recognizing impairments on securities that sustain credit declines in value. We have established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors including, but not limited to: (i) the extent to which the fair value is less than book value, (ii) the financial condition and near term prospects of the issuer, (iii) our intent and ability to retain impaired investments for a period of time sufficient to allow for any anticipated recovery in fair value, (iv) our intent to sell or the likelihood that we will need to sell a fixed maturity security before recovery of its amortized cost basis, (v) whether the debtor is current on interest and principal payments, (vi) the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors) and (vii) general market conditions and industry or sector specific factors. When a decision has been made to sell an impaired security or it is more likely than not that the impaired security will be required to be disposed of prior to recovery of its cost basis, the security is written down to fair value at the reporting date. For all other impaired securities, if the impairment is deemed to be credit related, an allowance is created.

Investment securities are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is possible that changes in these risk factors in the near term could have a material adverse impact on our results of operations or shareholders' equity.

At December 31, 2024 and 2023, there were no individual investments that exceeded 10% of shareholders' equity.

At December 31, 2024 and 2023, there were nine and eleven, respectively, fixed maturity investments that did not produce income during the years then ended.

We had unfunded loan commitments to certain equity investees of $1,442 and $1,321 at December 31, 2024 and 2023, respectively. We do not believe such obligations will materially affect its financial position, results of operations, or cash flows.

As of December 31, 2024 and 2023, we had committed approximately $423 and $497, respectively, to future investments in rated notes.

At December 31, 2024 and 2023, securities with carrying values of approximately $1,035 and $876, respectively, were deposited by our insurance subsidiaries under requirements of regulatory authorities.

Accrued Investment Income

Accrued investment income totaled $287 and $301 at December 31, 2024 and 2023, respectively. We recognize accrued investment income under the caption "Other receivables" on our consolidated balance sheets.

Securities Lending Programs

The fair value of the cash and securities received as collateral for securities loaned at December 31, 2024 and 2023 was $2,305 and $2,380, respectively. The collateral received was 102% of the market value of the loaned securities at each of December 31, 2024 and 2023.

We recognize the collateral as an asset under the caption "Other current assets" in our consolidated balance sheets, and we recognize a corresponding liability for the obligation to return the collateral to the borrower under the caption "Other current liabilities." The securities on loan are reported in the applicable investment category on our consolidated balance sheets.

At December 31, 2024 and 2023, the remaining contractual maturities of our securities lending transactions included overnight and continuous transactions of cash for $2,115 and $2,255, respectively, United States Government securities for $176 and $99, respectively, and residential mortgage-backed securities for $14 and $26, respectively.

6. Derivative Financial Instruments

We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, collars, swaptions, embedded derivatives and warrants. We also enter into master netting agreements which reduce credit risk by permitting net settlement of transactions. At December 31, 2024 and 2023, we had posted collateral of $142 and $35, respectively, related to our derivative financial instruments.

A summary of the aggregate contractual or notional amounts and carrying values related to derivative financial instruments at December 31, 2024 and 2023 is as follows:

	Contractual/ Notional Amount	Balance Sheet Location	Carrying Value Asset	Carrying Value (Liability)
December 31, 2024				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 6,475	Other assets/other liabilities	$ 8	$ (150)
Foreign currency forwards	322	Other liabilities	—	(6)
Subtotal hedging	6,797		8	(156)
Non-hedging instruments				
Interest rate swaps	5		—	—
Options	2,453	Other liabilities	—	(1,415)
Futures/Forwards	124	Equity securities/other assets	3	—
Subtotal non-hedging	2,582	Subtotal non-hedging	3	(1,415)
Total derivatives	$ 9,379	Total derivatives	11	(1,571)
		Amounts netted	(6)	6
		Net derivatives	$ 5	$ (1,565)
December 31, 2023				
Hedging instruments				
Interest rate swaps - fixed to floating	$ 1,475	Other assets/other liabilities	$ 15	$ (52)
Non-hedging instruments				
Derivatives embedded in convertible securities	15	Fixed maturity securities	1	—
Interest rate swaps	5		—	—
Options	161	Other liabilities	—	(85)
Collars	19	Equity securities	14	(3)
Futures/Forwards	151	Equity securities/other assets	7	—
Subtotal non-hedging	351	Subtotal non-hedging	22	(88)
Total derivatives	$ 1,826	Total derivatives	37	(140)
		Amounts netted	(15)	15
		Net derivatives	$ 22	$ (125)

Fair Value Hedges

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to the Secured Overnight Financing Rate. A summary of our outstanding fair value hedges at December 31, 2024 and 2023 is as follows:

Type of Fair Value Hedges	Year Entered Into	Outstanding Notional Amount		Interest Rate Received	Expiration Date
		2024	2023		
Interest rate swap	2024	$ 200	$ —	5.500 %	April 15, 2032
Interest rate swap	2024	1,000	—	4.750	August 15, 2032
Interest rate swap	2024	600	—	5.150	December 15, 2028
Interest rate swap	2024	1,000	—	5.375	December 15, 2033
Interest rate swap	2024	750	—	4.750	August 15, 2029
Interest rate swap	2024	750	—	4.950	May 1, 2031
Interest rate swap	2024	1,200	—	5.200	August 15, 2034
Interest rate swap	2023	300	300	5.000	April 15, 2032
Interest rate swap	2023	150	150	2.550	September 15, 2030
Interest rate swap	2023	—	500	4.900	February 8, 2026
Interest rate swap	2023	125	125	4.101	September 1, 2027
Interest rate swap	2023	100	100	2.250	November 15, 2029
Interest rate swap	2022	150	150	5.500	April 15, 2032
Interest rate swap	2022	75	75	4.101	September 1, 2027
Interest rate swap	2022	75	75	2.250	November 15, 2029
Total notional amount outstanding		$ 6,475	$ 1,475		

The following amounts were recorded on our consolidated balance sheets related to cumulative basis adjustments for fair value hedges at December 31, 2024 and 2023:

Balance Sheet Classification in Which Hedged Item is Included	Carrying Amount of Hedged Liability		Cumulative Amount of Fair Value Hedging Adjustment Included in the Carrying Amount of the Hedged Liability	
	2024	2023	2024	2023
Long-term debt	$ 29,218	$ 23,246	$ (142)	$ (37)

Cash Flow Hedges

We have entered into a series of forward starting pay fixed interest rate swaps with the objective of eliminating the variability of cash flows in the interest payments on future financings that were anticipated at the time of entering into the swaps. During 2024 and 2023, swaps in the notional amount of $900 and $550, respectively, were terminated.

The unrecognized loss for all expired and terminated cash flow hedges included in accumulated other comprehensive loss, net of tax, was $201 and $211 at December 31, 2024 and 2023, respectively. As of December 31, 2024, the total amount of amortization over the next twelve months for all cash flow hedges is estimated to increase interest expense by approximately $13. No amounts were excluded from effectiveness testing.

Non-Hedging Derivatives

A summary of the effect of non-hedging derivatives on our consolidated statements of income for the years ended December 31, 2024, 2023 and 2022 is as follows:

Type of Non-hedging Derivatives	Income Statement Location of Gain (Loss) Recognized	Derivative (Loss) Gain Recognized
Year ended December 31, 2024		
Options (including swaptions)	Net losses on financial instruments	$ (1)
Collars	Net losses on financial instruments	14
Futures	Net losses on financial instruments	(3)
Total		$ 10
Year ended December 31, 2023		
Derivatives embedded in convertible securities	Net losses on financial instruments	$ (2)
Options (including swaptions)	Net losses on financial instruments	3
Collars	Net losses on financial instruments	(3)
Futures	Net losses on financial instruments	10
Total		$ 8
Year ended December 31, 2022		
Derivatives embedded in convertible securities	Net losses on financial instruments	$ (3)
Interest rate swaps	Net losses on financial instruments	(4)
Options (including swaptions)	Net losses on financial instruments	13
Collars	Net losses on financial instruments	10
Futures		64
Total		$ 80

In connection with our equity investment in Mosaic Health (see Note 5, “Investments”), we entered into a limited partnership and related agreements with the majority owners that provides for certain rights and obligations of each party, including certain put, call, and purchase price true-up options. These options, if exercised, will result in our purchase of the units held by the majority owners as early as 2028 but no later than 2030 at a price based on certain multiples of revenue and earnings of Mosaic Health businesses, subject to various adjustments and qualifications. We have calculated the fair value of the net put option, which is a Level III measurement (see Note 7, “Fair Value”), using a Monte Carlo simulation, which relies on assumptions including cash flow projections, risk-free rates, volatility and details specific to the options. Significant changes in assumptions could result in significantly lower or higher fair value measurements. The net put option’s fair value liability of $1,330, which is a non-cash item measured at the date of our initial investment, is included under the caption “Other noncurrent liabilities” in our consolidated balance sheets as of December 31, 2024. We have elected to not mark the net put option to market, as it is an option on large blocks of equity securities, and the carrying value of the net put option will remain on the consolidated balance sheets until it is exercised or expires.

As discussed in Note 5, “Investments,” in January 2023, we made an equity investment that resulted in our minority interest ownership of Liberty Dental. As part of the Liberty Dental transaction, we entered into a shareholders’ agreement with the majority owners that provides for certain rights and obligations of each party, including certain put and call options. These options could result in our purchase of the units held by the majority owners in 2026 and 2027. We have calculated the fair value of the net put option, which is a Level III measurement (see Note 7, “Fair Value”), using a Monte Carlo simulation, which relies on assumptions, including cash flow projections, risk-free rates, volatility and details specific to the put and call options. Significant changes in assumptions could result in significantly lower or higher fair value measurements. The net put option’s fair value liability of $85 determined as of December 31, 2023 is included under the caption “Other noncurrent liabilities” in our consolidated balance sheets as of December 31, 2024 and 2023. We have elected to not mark the net put option to market, and the carrying value of the net put option will remain on the consolidated balance sheets until it is exercised or expires.

7. Fair Value

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

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

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in the consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less and are purchased daily at par value with specified yield rates. Due to the short-term nature of the funds, we designate all cash equivalents as Level I.

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions, mortgage-backed securities, United States Government securities, foreign government securities, and certain other asset-backed securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily collateralized loan obligation securities, rated note securities and corporate debt securities, that are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes, net asset value of underlying loans or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available, and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, and/or revenue multiples that are not observable in the markets.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third-party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

Derivatives: Fair values are generally based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate market observable inputs for similar derivative transactions. These derivatives are designated as Level II securities. Fair values of certain derivatives where market observable inputs are not available are estimated using

assumptions such as cash flow projections, risk-free rates, volatility and details specific to the derivative contract. These derivatives are designated as Level III securities.

In addition, the following methods and assumptions were used to determine the fair value of each class of pension benefit plan assets and other benefit plan assets not defined above (see Note 11, "Retirement Benefits," for fair values of benefit plan assets):

Mutual funds: Fair values are based on quoted market prices, which represent the net asset value ("NAV") of shares held.

Partnership investments: Fair values are estimated based on the plan's ownership share of the partnerships' net assets, as reported in their periodic capital statements, and are valued using NAV as a practical expedient. The partnerships primarily consist of a real estate investment fund which acquires investments in real estate entities, and an energy fund which invests in public and private oil and gas companies principally through privately issued securities.

Collective investment trusts ("CITs"): Fair values are based on the NAV of the units held by the plan at year end and are valued using NAV as a practical expedient. The CITs are passive index funds that seek investment results that generally correspond to the performance of the Bloomberg U.S. Intermediate Treasury Index.

Commingled fund: Fair value is based on NAV per fund share and is valued using NAV as a practical expedient. The fund primarily invests in publicly traded equity securities of issuers within the fund's benchmark. The objective of the fund is to produce returns in excess of the relevant benchmark over rolling five-year periods.

Insurance company contracts: Fair value is based on the fair value of the underlying investments of the account as determined by the insurance company.

Investment in DOL 103-12 trust: Fair value is based on the plan's proportionate share of the fair value of investments held by the trust, qualified as a Department of Labor Regulation 2520.103-12 entity ("DOL 103-12 trust") as reported in the audited financial statements of the trust, where the trustee applies fair value measurements to the underlying investments of the trust.

Life insurance contracts: Fair value is based on the cash surrender value of the policies as reported by the insurance carriers.

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at December 31, 2024 and 2023 is as follows:

	Level I	Level II	Level III	Total
December 31, 2024				
Assets:				
Cash equivalents	$ 3,199	$ —	$ —	$ 3,199
Fixed maturity securities, available-for-sale:				
United States Government securities	—	1,824	—	1,824
Government sponsored securities	—	151	—	151
Foreign government securities	—	17	—	17
States, municipalities and political subdivisions, tax-exempt	—	3,052	—	3,052
Corporate securities	—	13,873	43	13,916
Residential mortgage-backed securities	—	3,041	10	3,051
Commercial mortgage-backed securities	—	1,748	—	1,748
Other asset-backed securities	—	1,730	747	2,477
Total fixed maturity securities, available-for-sale	—	25,436	800	26,236
Equity securities:				
Exchange traded funds	1,002	—	—	1,002
Common equity securities	87	31	—	118
Private equity securities	—	—	72	72
Total equity securities	1,089	31	72	1,192
Other invested assets - common equity securities	18	—	—	18
Securities lending collateral	—	2,306	—	2,306
Derivatives - other assets	—	5	—	5
Total assets	$ 4,306	$ 27,778	$ 872	$ 32,956
Liabilities:				
Derivatives - other liabilities	$ —	$ (150)	$ —	$ (150)
Total liabilities	$ —	$ (150)	$ —	$ (150)
December 31, 2023				
Assets:				
Cash equivalents	$ 2,210	$ —	$ —	$ 2,210
Fixed maturity securities, available-for-sale:				
United States Government securities	—	1,844	—	1,844
Government sponsored securities	—	110	—	110
Foreign government securities	—	4	—	4
States, municipalities and political subdivisions, tax-exempt	—	3,902	—	3,902
Corporate securities	—	14,532	46	14,578
Residential mortgage-backed securities	—	3,830	2	3,832
Commercial mortgage-backed securities	—	2,047	—	2,047
Other asset-backed securities	—	3,634	539	4,173
Total fixed maturity securities, available-for-sale	—	29,903	587	30,490
Equity securities:				
Exchange traded funds	106	—	—	106
Common equity securities	12	33	—	45
Private equity securities	—	—	78	78
Total equity securities	118	33	78	229
Other invested assets - common equity securities	111	—	—	111
Securities lending collateral	—	2,382	—	2,382
Derivatives - other assets	—	10	—	10
Total assets	$ 2,439	$ 32,328	$ 665	$ 35,432
Liabilities:				
Derivatives - other liabilities	$ —	$ (40)	$ —	$ (40)
Total liabilities	$ —	$ (40)	$ —	$ (40)

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the years ended December 31, 2024, 2023 and 2022 is as follows:

	Corporate Securities	Residential Mortgage-backed Securities	Other Asset-Backed Securities	Equity Securities	Total
Year ended December 31, 2024					
Beginning balance at January 1, 2024	$ 46	$ 2	$ 539	$ 78	$ 665
Total gains (losses):					
Recognized in net income	1	—	—	(6)	(5)
Recognized in accumulated other comprehensive income	—	—	12	—	12
Purchases	26	10	118	17	171
Sales	(5)	(2)	(10)	(17)	(34)
Settlements	(4)	—	(1)	—	(5)
Transfers into Level III	—	—	92	—	92
Transfers out of Level III	(21)	—	(3)	—	(24)
Ending balance at December 31, 2024	$ 43	$ 10	$ 747	$ 72	$ 872
Change in unrealized gains or losses included in net income related to assets still held at December 31, 2024	$ —	$ —	$ —	$ (5)	$ (5)
Year ended December 31, 2023					
Beginning balance at January 1, 2023	$ 137	$ —	$ 356	$ 88	$ 581
Total gains (losses):					
Recognized in net income	(10)	—	—	(4)	(14)
Recognized in accumulated other comprehensive income	6	—	3	—	9
Purchases	38	—	191	15	244
Sales	(88)	—	(17)	(21)	(126)
Settlements	(21)	—	—	—	(21)
Transfers into Level III	6	2	6	—	14
Transfers out of Level III	(22)	—	—	—	(22)
Ending balance at December 31, 2023	$ 46	$ 2	$ 539	$ 78	$ 665
Change in unrealized gains or losses included in net income related to assets still held at December 31, 2023	$ —	$ —	$ —	$ (6)	$ (6)
Year ended December 31, 2022					
Beginning balance at January 1, 2022	$ 336	$ 5	$ 19	$ 89	$ 449
Total gains (losses):					
Recognized in net income	—	—	(1)	—	(1)
Recognized in accumulated other comprehensive income	(1)	—	(16)	—	(17)
Purchases	56	—	370	17	443
Sales	(210)	—	(14)	(18)	(242)
Settlements	(41)	—	—	—	(41)
Transfers into Level III	9	—	—	—	9
Transfers out of Level III	(12)	(5)	(2)	—	(19)
Ending balance at December 31, 2022	$ 137	$ —	$ 356	$ 88	$ 581
Change in unrealized gains or losses included in net income related to assets still held at December 31, 2022	$ —	$ —	$ —	$ —	$ —

There were no individually material transfers into or out of Level III during the years ended December 31, 2024, 2023 or 2022.

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. As disclosed in Note 3, “Business Acquisitions and Divestitures,” we completed our acquisitions of Centers, CareBridge and Paragon in 2024 and BioPlus in 2023. The net assets acquired in these acquisitions and resulting goodwill and other intangible assets were recorded at fair value primarily using Level III inputs. The majority of assets acquired and liabilities assumed were recorded at their carrying values as of the respective date of acquisition, as their carrying values approximated their fair values due to

their short-term nature. The fair values of goodwill and other intangible assets acquired in our acquisitions of Centers, CareBridge, Paragon and BioPlus were estimated based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets could be expected to generate in the future. We developed internal estimates for the expected cash flows and discount rate in the present value calculation.

Also, we entered into agreements which included certain put and call options associated with our minority interest ownership of Mosaic Health in 2024 and Liberty Dental in 2023. The resulting net put option liabilities were recorded at their fair values measured at the dates of acquisition using Level III inputs with an election not to mark the derivative to market, which is further discussed and disclosed in Note 6, "Derivatives". The net put option carrying value for Mosaic Health was $1,330 at December 31, 2024. The net put option fair value for Liberty Dental was $543 and $85 at December 31, 2024 and 2023, respectively.

Other than the assets acquired and liabilities assumed in our acquisitions of CareBridge, Centers, Paragon and BioPlus and the net put options on Mosaic Health and Liberty Dental described above, there were no material assets or liabilities measured at fair value on a nonrecurring basis during the years ended December 31, 2024 or 2023.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes, unobservable inputs or other valuation techniques. These techniques are significantly affected by our assumptions, including discount rates and estimates of future cash flows. The use of assumptions for unobservable inputs for the determination of fair value involves a level of judgment and uncertainty. Changes in assumptions that reasonably could have been different at the reporting date may result in a higher or lower determination of fair value. Changes in fair value measurements, if significant, may affect performance of cash flows.

Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain quoted prices for each security from third-party pricing services, which are derived through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available market observable information. As we are responsible for the determination of fair value, we perform analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes procedures such as a review of month-to-month price fluctuations and price comparisons to secondary pricing services. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2024, 2023 or 2022.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in the consolidated balance sheets.

Non-financial instruments such as property and equipment, other current assets, deferred income taxes, intangible assets and certain financial instruments, such as limited partnerships, joint ventures, other non-controlled corporations, corporate-owned life insurance policies, and policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash, premium receivables, self-funded receivables, other receivables, unearned income, accounts payable and accrued expenses, and certain other current liabilities approximate fair value because of the short-term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument that is recorded at its carrying value on the consolidated balance sheets:

Other invested assets: Other invested assets primarily include our mortgage loans and notes receivables. Mortgage loans are carried at amortized cost net of loss allowance. The fair value of mortgage loans is measured using discounted cash flows benchmarked against the 10-year U.S. Treasury yield plus a market rate spread. The notes receivables are measured at their amortized cost. The fair value of notes receivables is the present value of discounted future cash flows.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—senior unsecured notes and surplus notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

Options: The options consist of put, call and purchase price true-up options associated with our equity investment in the Mosaic Health joint venture and the put and call options associated with our equity investment in Liberty Dental. The fair value of the net put option associated with Mosaic Health is based on a Monte Carlo simulation, which relies on assumptions including cash flow projections, risk-free rates, volatility and details specific to the options. The fair value of the net put option associated with Liberty Dental is based on the discounted present value of estimated future option exercise prices.

A summary of the estimated fair values by level of each class of financial instrument that is recorded at its carrying value on our consolidated balance sheets at December 31, 2024 and 2023 is as follows:

	Carrying Value	Estimated Fair Value			
		Level I	Level II	Level III	Total
December 31, 2024					
Assets:					
Other invested assets	$ 642	$ —	$ —	$ 610	$ 610
Liabilities:					
Debt:					
Short-term borrowings	365	—	365	—	365
Notes	30,867	—	28,460	—	28,460
Options	1,415	—	—	1,873	1,873
December 31, 2023					
Assets:					
Other invested assets	$ 302	$ —	$ —	$ 278	$ 278
Liabilities:					
Debt:					
Short-term borrowings	225	—	225	—	225
Notes	24,895	—	23,569	—	23,569
Options	85	—	—	85	85

8. Income Taxes

The components of deferred income taxes at December 31, 2024 and 2023 are as follows:

	2024	2023
Deferred income tax assets:		
Accrued expenses	$ 826	$ 595
Bad debt reserves	434	415
Insurance reserves	192	178
Lease liabilities	170	172
Retirement liabilities	126	132
Deferred compensation	45	44
Federal and state carryforwards	428	368
Foreign (including Puerto Rico) carryforwards	90	87
Other	100	166
Subtotal	2,411	2,157
Less: valuation allowance	(294)	(271)
Total deferred income tax assets	2,117	1,886
Deferred income tax liabilities:		
U.S. federal and state intangible assets	2,584	2,043
Foreign (including Puerto Rico) intangible assets	194	330
Capitalized software	513	485
Depreciation and amortization	38	81
Investment basis	11	11
Retirement assets	330	319
Lease right-of-use assets	114	110
Prepaid expenses	275	249
Total deferred income tax liabilities	4,059	3,628
Net deferred income tax liabilities	$ 1,942	$ 1,742

We recognized $206 and $228 of deferred tax asset under the caption “Other noncurrent assets” at December 31, 2024 and 2023, respectively. We recognized $2,148 and $1,970 of deferred tax liability under the caption “Deferred tax liabilities, net” at December 31, 2024 and 2023, respectively.

As of December 31, 2024, we have established U.S. deferred taxes for undistributed earnings from certain non-U.S. subsidiaries, which are included in the Investment basis component above, consistent with prior years.

Significant components of the provision for income taxes for the years ended December 31, 2024, 2023 and 2022 consist of the following:

	2024	2023	2022
Current tax expense:			
Federal	$ 1,753	$ 1,899	$ 1,455
Foreign (including Puerto Rico)	93	95	98
State and local	448	420	244
Total current tax expense	2,294	2,414	1,797
Deferred tax benefit	(361)	(690)	(85)
Total income tax expense	$ 1,933	$ 1,724	$ 1,712

State and local current tax expense is reported gross of federal benefit in the preceding table, and includes amounts related to audit settlements, uncertain tax positions, state tax credits and true up of prior years' tax. Such items are included on a net of federal tax basis in multiple lines in the following rate reconciliation table.

A reconciliation of income tax expense recorded in the consolidated statements of income and amounts computed at the statutory federal income tax rate for the years ended December 31, 2024, 2023 and 2022 is as follows:

	2024		2023		2022	
	Amount	Percent	Amount	Percent	Amount	Percent
Amount at statutory rate	$ 1,660	21.0 %	$ 1,620	21.0 %	$ 1,596	21.0 %
State and local income taxes net of federal tax expense/benefit	216	2.7	124	1.6	190	2.5
Tax exempt interest and dividends received deduction	(12)	(0.1)	(15)	(0.2)	(19)	(0.3)
Change in valuation allowance	43	0.6	84	1.1	51	0.7
Other, net	26	0.3	(89)	(1.2)	(106)	(1.4)
Total income tax expense	$ 1,933	24.5 %	$ 1,724	22.3 %	$ 1,712	22.5 %

During the year ended December 31, 2024, we recognized income tax expense of $1,933, or $8.30 per diluted share. The increase in effective income tax rate for 2024 compared to 2023 was primarily due to the impact of geographic changes in the mix of 2024 earnings.

During the year ended December 31, 2023, we recognized income tax expense of $1,724, or $7.26 per diluted share. The decrease in effective income tax rate for 2023 compared to 2022 was primarily due to the impact of geographic changes in the mix of 2023 earnings.

During the year ended December 31, 2022, we recognized income tax expense of $1,712, or $7.05 per diluted share.

The change in the carrying amount of gross unrecognized tax benefits from uncertain tax positions for the years ended December 31, 2024 and 2023 is as follows:

	2024	2023
Balance at January 1	$ 468	$ 349
Additions based on:		
Tax positions related to current year	146	19
Tax positions related to prior years	216	119
Reductions based on:		
Tax positions related to prior years	(55)	(19)
Balance at December 31	$ 775	$ 468

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under our accounting policy. The interest is included in the amounts described in the following paragraph.

The amount of unrecognized tax benefits that would impact our effective tax rate in future periods, if recognized, was $804 and $450 at December 31, 2024 and 2023, respectively. Also included in the table above, at December 31, 2024, is $2 that would be recognized as an adjustment to additional paid-in capital, which would not affect our effective tax rate.

For the years ended December 31, 2024, 2023 and 2022, we recognized net interest expense of $57, $24 and $13, respectively. We had accrued approximately $165 and $79 for the payment of interest at December 31, 2024 and 2023, respectively. For the years ended December 31, 2024, 2023 and 2022 we recognized net penalty expense of $7, $17 and $0, respectively. We had accrued approximately $85 and $60 for the payment of penalties at December 31, 2024 and 2023, respectively.

As of December 31, 2024, as further described below, certain tax years remain open to examination by the Internal Revenue Service ("IRS") and various state, local and foreign authorities. As a result of these examinations and discussions with taxing agencies, we have recorded amounts for uncertain tax positions. It is anticipated that the amount of unrecognized tax benefits will change in the next twelve months due to possible settlements of audits and changes in temporary items. However, the ultimate resolution of these items is dependent on the completion of negotiations with various taxing authorities. While it is difficult to determine when other tax settlements will actually occur, it is reasonably possible that one could occur in the next twelve months and our unrecognized tax benefits could be reduced within a range of approximately $137 to $475.

We are a member of the IRS Compliance Assurance Process ("CAP"). The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post-filing examinations. As of December 31, 2024, the IRS examination of our 2024, 2023 and 2022 tax years continues to be in process.

In certain states, we pay premium taxes in lieu of state income taxes. Premium taxes are reported in operating expense.

At December 31, 2024, we had federal net operating loss carryforwards of $54, of which $33 will expire beginning 2032 through 2044 and $21 have an indefinite carryforward period. State and local net operating loss carryforwards of $256, of which $194 will expire beginning 2025 through 2044, and $62 have an indefinite carryforward period. Foreign net operating loss carryforward of $90 will expire beginning 2033.

Income taxes receivable totaled $138 and $543 at December 31, 2024 and 2023, respectively. We recognized the income tax receivable of $213 and $543 as an asset under the caption "Other current assets" and the income tax payable of $75 and $0 as a liability under the caption "Other current liabilities" in our consolidated balance sheets as of December 31, 2024 and December 31, 2023, respectively.

During 2024, 2023 and 2022, federal income taxes paid totaled $1,303, $1,936 and $1,594, respectively.

9. Property and Equipment

A summary of property and equipment at December 31, 2024 and 2023 is as follows:

	2024	2023
Computer software, purchased and internally developed	$ 6,617	$ 6,195
Computer equipment, furniture and other equipment	940	955
Leasehold improvements	744	715
Building and improvements	27	37
Land and improvements	1	1
Property and equipment, gross	8,329	7,903
Accumulated depreciation and amortization	(3,677)	(3,544)
Property and equipment, net	$ 4,652	$ 4,359

Depreciation expense for 2024, 2023 and 2022 was $105, $107 and $123, respectively. Amortization expense on computer software and leasehold improvements for 2024, 2023 and 2022 was $809, $765 and $661, respectively, which includes amortization expense on computer software, both purchased and internally developed, for 2024, 2023 and 2022 of $734, $685 and $599, respectively. Capitalized costs related to the internal development of software of $6,363 and $5,870 at December 31, 2024 and 2023, respectively, are reported with computer software.

Impairment of property and equipment for the years ended December 31, 2024, 2023 and 2022 was $72, $446, and $7, respectively, which is included in Operating expenses and primarily related to our activities disclosed in Note 4, “Business Optimization Initiatives.”

10. Goodwill and Other Intangible Assets

A summary of the change in the carrying amount of goodwill for our segments (see Note 20, “Segment Information”) for 2024 and 2023 is as follows:

	Health Benefits	CarelonRx	Carelon Services	Total
Balance as of January 1, 2023	$ 22,088	$ 59	$ 2,236	$ 24,383
Acquisitions and adjustments	16	898	20	934
Balance as of December 31, 2023	22,104	957	2,256	25,317
Acquisitions and adjustments	460	958	1,542	2,960
Balance as of December 31, 2024	$ 22,564	$ 1,915	$ 3,798	$ 28,277
Accumulated impairment as of December 31, 2024	$ —	$ —	$ (106)	$ (106)

As required by FASB guidance, we completed annual impairment tests of existing goodwill and other intangible assets with indefinite lives during 2024, 2023 and 2022. We perform these annual impairment tests during the fourth quarter. FASB guidance also requires interim impairment testing to be performed when potential impairment indicators exist. These tests involve the use of estimates related to the estimated fair value of goodwill and intangible assets with indefinite lives and require a significant degree of management judgment and the use of subjective assumptions. Qualitative testing procedures include assessing our financial performance, macroeconomic conditions, industry and market considerations, various asset specific factors and entity specific events. For quantitative testing, the fair values are estimated using the projected income and market valuation approaches, incorporating Level III internal estimates for inputs, including, but not limited to, revenue projections, income projections, cash flows and discount rates.

In 2024, we incurred goodwill impairment losses of $106 in our Carelon Services reporting segment specific to the fair valuation of the CMSI assets included in assets and liabilities held for sale as discussed in Note 5, “Investments.” Otherwise, the estimated fair values of our reporting units were substantially in excess of their carrying values.

We did not incur any impairment losses in 2023 or 2022, as the estimated fair values of our reporting units were substantially in excess of their carrying values.

The components of other intangible assets as of December 31, 2024 and 2023 are as follows:

	2024			2023		
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Intangible assets with finite lives:						
Customer relationships	$ 7,866	$ (4,233)	$ 3,633	$ 6,263	$ (3,817)	$ 2,446
Provider and hospital relationships	377	(165)	212	326	(164)	162
Other	423	(67)	356	242	(44)	198
Total	8,666	(4,465)	4,201	6,831	(4,025)	2,806
Intangible assets with indefinite lives:						
Blue Cross and Blue Shield and other trademarks	5,991	—	5,991	5,991	—	5,991
State Medicaid licenses	1,902	—	1,902	1,476	—	1,476
Total	7,893	—	7,893	7,467	—	7,467
Other intangible assets	$ 16,559	$ (4,465)	$ 12,094	$ 14,298	$ (4,025)	$ 10,273

In 2024, additions to the gross carrying amount of customer relationships primarily relate to the acquisitions of Centers, CareBridge and Paragon.

Intangible assets with finite lives, along with the related accumulated amortization, are removed from the table above at the end of the fiscal year in which they become fully amortized.

As of December 31, 2024, the estimated amortization expense for each of the five succeeding years is as follows: 2025, $671; 2026, $474; 2027, $428; 2028, $377; and 2029, $317.

11. Retirement Benefits

We sponsor various non-contributory employee defined benefit plans through certain subsidiaries. Future benefit accruals for these plans are frozen, but participants continue to earn interest on existing account balances. We also have a post-retirement health and welfare plan that primarily provides healthcare benefits to certain eligible employees. The majority of the pension and post-retirement plans are over funded. We fund our qualified pension plans at least sufficient to meet minimum amounts required by law. Pension and post-retirement healthcare plan expenses and valuations are dependent on assumptions used by third-party actuaries in calculating those amounts. These assumptions include discount rates, healthcare cost trends, long-term return on plan assets, retirement rates, mortality rates and other factors.

The reconciliation of the benefit obligations for the plans is as follows:

	Pension Benefits		Other Benefits	
	2024	2023	2024	2023
Benefit obligation at beginning of year	$ 1,393	$ 1,415	$ 255	$ 277
Interest cost	63	68	12	14
Plan participant contributions	—	—	16	16
Actuarial (gain) loss	(61)	40	(10)	(12)
Settlements	(27)	(27)	—	—
Benefits paid	(105)	(103)	(35)	(40)
Benefit obligation at end of year	$ 1,263	$ 1,393	$ 238	$ 255

The changes in the fair value of plan assets are as follows:

	Pension Benefits		Other Benefits	
	2024	2023	2024	2023
Fair value of plan assets at beginning of year	$ 1,807	$ 1,734	$ 313	$ 299
Actual return on plan assets	83	199	29	42
Employer contributions	6	4	—	—
Plan participant contributions	—	—	16	16
Settlements	(27)	(27)	4	—
Benefits paid	(105)	(103)	(37)	(44)
Fair value of plan assets at end of year	$ 1,764	$ 1,807	$ 325	$ 313

The amounts included in the consolidated balance sheets are as follows:

	Pension Benefits		Other Benefits	
	2024	2023	2024	2023
Noncurrent assets	$ 539	$ 459	$ 87	$ 58
Current liabilities	(4)	(7)	—	—
Noncurrent liabilities	(34)	(38)	—	—
Net amount at end of year	$ 501	$ 414	$ 87	$ 58

Our estimated future payments for pension benefits and other benefits are as follows:

	Pension Benefits	Other Benefits
2025	$ 128	$ 26
2026	112	26
2027	109	25
2028	106	24
2029	103	24
2030 - 2034	472	99

The components of net periodic benefit credit included in the consolidated statements of income are as follows:

	2024	2023	2022
Pension Benefits			
Interest cost	$ 63	$ 68	$ 52
Expected return on assets	(117)	(127)	(101)
Recognized actuarial loss	14	9	16
Settlement loss	6	7	28
Net periodic benefit credit	$ (34)	$ (43)	$ (5)
Other Benefits			
Interest Cost	$ 12	$ 14	$ 7
Expected return on assets	(22)	(21)	(26)
Amortization of prior service credit	(1)	(2)	(4)
Recognized actuarial gain	(1)	—	—
Net periodic benefit credit	$ (12)	$ (9)	$ (23)

The net amounts included in accumulated other comprehensive income (loss) that have not been recognized as components of net periodic benefit costs are as follows:

	Pension Benefits		Other Benefits	
	2024	2023	2024	2023
Net actuarial gain (loss)	$ (580)	$ (625)	$ 55	$ 38
Prior service credit	—	—	—	2
Net amount before tax at end of year	$ (580)	$ (625)	$ 55	$ 40

The pre-tax amounts recognized in other comprehensive loss are as follows:

	2024	2023	2022
Pension Benefits			
Net actuarial gain (loss)	$ 25	$ 31	$ (91)
Recognized actuarial loss	14	9	16
Settlement loss	6	7	28
Total pre-tax other comprehensive income (loss)	$ 45	$ 47	$ (47)
Other Benefits			
Net actuarial gain (loss)	$ 17	$ 34	$ (32)
Recognized actuarial gain	(1)	—	—
Prior service credit	(1)	(2)	(5)
Total pre-tax other comprehensive income (loss)	$ 15	$ 32	$ (37)

The accumulated benefit obligation for the defined benefit pension plans was $1,262 and $1,391 at December 31, 2024 and 2023, respectively.

As of December 31, 2024, certain pension plans had accumulated benefit obligations in excess of plan assets. Such plans had accumulated benefit obligation and fair value of plan assets of $38 and $0, respectively. In addition, certain plans had projected benefit obligations in excess of plan assets. Such plans had projected benefit obligation and fair value of plan assets of $38 and $0, respectively.

The following table represents the significant weighted-average actuarial assumptions for all plans:

	Pension Benefits		Other Benefits	
	2024	2023	2024	2023
Benefit Obligation				
Discount rate	5.47 %	4.91 %	5.34 %	4.83 %
Interest Crediting rate	4.50 %	4.50 %	4.36 %	4.50 %

The following table represents the significant weighted-average actuarial assumptions for all plans:

	2024	2023	2022
Net Periodic Benefit Cost			
Pension Benefits			
Discount rate	4.91 %	5.18 %	2.70 %
Expected rate of return on plan assets	6.47 %	6.58 %	5.02 %
Interest crediting rate	4.50 %	4.25 %	3.82 %
Other Benefits			
Discount rate	4.83 %	5.12 %	2.49 %
Expected rate of return on plan assets	6.64 %	6.57 %	6.43 %
Interest crediting rate	4.50 %	3.89 %	1.56 %

The assumed healthcare cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) benefits at December 31, 2024 was 8.00% for 2025, with a gradual decline to 4.50% by the year 2035. The assumed healthcare cost trend rates used to measure the expected medical and pharmacy cost of post-Medicare (those who are currently eligible for Medicare benefits) benefits at December 31, 2024 was 5.50% and 10.00% for 2025, respectively, both with a gradual decline to 4.50% by the year 2035. These estimated trend rates are subject to change in the future.

Plan assets include a diversified mix of equity securities, investment grade fixed maturity securities and other types of investments across a range of sectors and levels of capitalization to maximize long-term return for a prudent level of risk. The weighted-average target allocation for pension benefit plan assets is 35% equity securities, 63% fixed maturity securities, and 2% to all other types of investments. Equity securities primarily include a mix of domestic securities, foreign securities and mutual funds invested in equities. Fixed maturity securities primarily include corporate bonds, treasury securities and asset-backed investments issued by corporations and the U.S. government. Other types of investments include insurance contracts designed specifically for employee benefit plans, an investment in a DOL 103-12 trust and certain alternative investments.

As of December 31, 2024, there were no significant concentrations of investments in the pension benefit assets or other benefit assets. No plan assets were invested in Elevance Health common stock.

Pension benefit assets and other benefit assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value. In accordance with FASB guidance, certain alternative investments that are measured at fair value using the NAV per share (or its equivalent) as a practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented are intended to permit reconciliation of the fair value hierarchy to the total plan assets.

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2024, excluding cash, investment income receivable and amounts due to/from brokers of $30, and excluding estimated claims settlements to be paid from other benefit assets of $(19), are as follows (see Note 7, “Fair Value,” for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2024				
Pension Benefit Assets:				
Cash equivalents	$ 6	$ —	$ —	$ 6
Equity securities:				
U.S. securities	307	—	—	307
Foreign securities	71	—	—	71
Mutual funds	44	—	—	44
Fixed maturity securities:				
Government securities	—	78	—	78
Corporate securities	—	539	—	539
Asset-backed securities	—	3	—	3
Other types of investments:				
Insurance company contracts	—	—	143	143
Total pension benefit assets at fair value	$ 428	$ 620	$ 143	1,191
Alternative investments				543
Total pension benefit assets				$ 1,734
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 7	$ —	$ —	$ 7
Foreign securities	2	—	—	2
Mutual funds	16	—	—	16
Other types of investments:				
Life insurance contracts	—	—	301	301
Investment in DOL 103-12 trust	—	9	—	9
Total other benefit assets at fair value	$ 25	$ 9	$ 301	335
Alternative investments				9
Total other benefit assets				$ 344

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2023, excluding cash, investment income receivable and amounts due to/from brokers of $43, and excluding estimated claims settlements to be paid from other benefit assets of $(23), are as follows:

	Level I	Level II	Level III	Total
December 31, 2023				
Pension Benefit Assets:				
Cash equivalents	$ 2	$ —	$ —	$ 2
Equity securities:				
U.S. securities	390	—	—	$ 390
Foreign securities	94	—	—	94
Mutual funds	42	—	—	42
Fixed maturity securities:				
Government securities	—	70	—	70
Corporate securities	—	522	—	522
Asset-backed securities	—	2	—	2
Other types of investments:				
Insurance company contracts	—	—	143	143
Total pension benefit assets at fair value	$ 528	$ 594	$ 143	1,265
Alternative investments				500
Total pension benefit assets				$ 1,765
Other Benefit Assets:				
Equity securities:				
U.S. securities	$ 7	$ —	$ —	$ 7
Foreign securities	2	—	—	2
Mutual funds	17	—	—	17
Other types of investments:				
Life insurance contracts	—	—	289	289
Investment in DOL 103-12 trust	—	9	—	9
Total other benefit assets at fair value	$ 26	$ 9	$ 289	324
Alternative investments				11
Total other benefit assets				$ 335

The following table provides additional information on the alternative investments that are measured using NAV as a practical expedient:

	Fair Value as of December 31		Unfunded Commitments as of December 31, 2024	Redemption Frequency (if applicable)	Redemption Notice Period
	2024	2023			
Collective investment trusts:					
Pension benefit assets	$ 413	$ 346			
Other benefit assets	8	9			
Total CITs	421	355	$ —	Daily	2 days
Commingled fund:					
Pension benefit assets	69	84			
Other benefit assets	1	2			
Total commingled fund	70	86	—	1st & 15th of the month	7 business days
Partnership investments	61	70	1	Not Applicable	Not Applicable
Total alternative investments	$ 552	$ 511	$ 1		

A reconciliation of the beginning and ending balances of plan assets measured at fair value using Level III inputs for the years ended December 31, 2024, 2023 and 2022 is as follows:

	Insurance Company Contracts	Life Insurance Contracts	Total
Year ended December 31, 2024			
Beginning balance at January 1, 2024	$ 143	$ 289	$ 432
Actual return on plan assets relating to assets still held at the reporting date	3	28	31
Purchases	6	—	6
Sales	(9)	(16)	(25)
Ending balance at December 31, 2024	$ 143	$ 301	$ 444
Year ended December 31, 2023			
Beginning balance at January 1, 2023	$ 154	$ 270	$ 424
Actual return on plan assets relating to assets still held at the reporting date	3	37	40
Purchases	6	—	6
Sales	(20)	(18)	(38)
Ending balance at December 31, 2023	$ 143	$ 289	$ 432
Year ended December 31, 2022			
Beginning balance at January 1, 2022	$ 179	$ 338	$ 517
Actual return on plan assets relating to assets still held at the reporting date	(22)	(53)	(75)
Purchases	9	—	9
Sales	(12)	(15)	(27)
Ending balance at December 31, 2022	$ 154	$ 270	$ 424

There were no transfers into or out of Level III during the years ended December 31, 2024, 2023 or 2022.

In addition to the defined benefit plans, we maintain the Elevance Health 401(k) Plan, which is a qualified defined contribution plan covering substantially all employees. Voluntary employee contributions are matched by us subject to certain limitations. Contributions made by us totaled $314, $316 and $275 during 2024, 2023 and 2022, respectively.

12. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable for the years ended December 31, 2024, 2023 and 2022 is as follows:

	2024	2023	2022
Gross medical claims payable, beginning of year	$ 15,865	$ 15,348	$ 13,282
Ceded medical claims payable, beginning of year	(7)	(6)	(21)
Net medical claims payable, beginning of year	15,858	15,342	13,261
Business combinations and purchase adjustments	143	—	133
Net incurred medical claims:			
Current year	125,370	121,798	113,414
Prior years redundancies	(1,731)	(1,571)	(869)
Total net incurred medical claims	123,639	120,227	112,545
Net payments attributable to:			
Current year medical claims	110,930	107,146	98,997
Prior years medical claims	13,143	12,565	11,600
Total net payments	124,073	119,711	110,597
Net medical claims payable, end of year	15,567	15,858	15,342
Ceded medical claims payable, end of year	13	7	6
Gross medical claims payable, end of year	$ 15,580	$ 15,865	$ 15,348

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any period-end are continually reviewed and re-estimated as information regarding actual claims payments, or run out, becomes known. This information is compared to the originally established year end liability. Negative amounts reported for incurred medical claims related to prior years result from claims being settled for amounts less than originally estimated. The prior year redundancy of $1,731 shown above for the year ended December 31, 2024, represents an estimate based on paid claim activity from January 1, 2024 to December 31, 2024. Medical claim liabilities are usually described as having a “short tail,” which means that they are generally paid within twelve months of the member receiving service from the provider. Accordingly, the majority of the $1,731 redundancy relates to claims incurred in calendar year 2023.

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the years ended December 31, 2024, 2023 and 2022, which are the completion and trend factors. These vital assumptions can be affected by variables such as utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing and submission patterns, and operational changes resulting from business combinations.

	Favorable Developments by Changes in Key Assumptions		
	2024	2023	2022
Assumed trend factors	$ (688)	$ (895)	$ (859)
Assumed completion factors	(1,043)	(676)	(10)
Total	$ (1,731)	$ (1,571)	$ (869)

The favorable development recognized in 2024 resulted primarily from completion factors developing more favorably than originally expected as well as a smaller but significant contribution from trend factors in late 2023.

The favorable development recognized in 2023 resulted primarily from trend factors in late 2022 developing more favorably than originally expected. Favorable development in the completion factors in late 2022 also contributed to the favorable development in 2023.

The favorable development recognized in 2022 resulted primarily from trend factors in late 2021 developing more favorably than originally expected as well as a smaller contribution from completion factor development.

The reconciliation of net incurred medical claims to benefit expense included in the consolidated statements of income is as follows:

	Years Ended December 31		
	2024	2023	2022
Total net incurred medical claims	$ 123,639	$ 120,227	$ 112,545
Quality improvement and other claims expense	3,928	4,103	4,097
Benefit expense	$ 127,567	$ 124,330	$ 116,642

Incurred claims development, net of reinsurance, for the years ended December 31, 2024, 2023 and 2022 is as follows:

	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	2022 (Unaudited)	2023 (Unaudited)	2024
2022 & Prior	$ 125,938	$ 124,367	$ 124,041
2023		121,798	120,393
2024			125,513
Total			$ 369,947

Paid claims development, net of reinsurance, for the years ended December 31, 2024, 2023 and 2022 is as follows:

	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Years	2022 (Unaudited)	2023 (Unaudited)	2024
2022 & Prior	$ 110,597	$ 123,162	$ 123,849
2023		107,146	119,601
2024			110,930
Total			$ 354,380

At December 31, 2024, the total of incurred but not reported liabilities plus expected development on reported claims was $192, $792 and $14,583 for the claim years 2022 and prior, 2023 and 2024, respectively.

At December 31, 2024, the cumulative number of reported claims was 507, 497 and 454 for the claim years 2022 and prior, 2023 and 2024, respectively.

The information about incurred claims development, paid claims development and cumulative number of reported claims for the years ended December 31, 2022 and 2023 is unaudited and presented as supplementary information.

The cumulative number of reported claims for each claim year has been developed using historical data captured by our claim payment systems. The provided claim amounts are not a precise tool for understanding utilization of medical services. They could be impacted by a variety of factors, including changes in provider billing practices, provider reimbursement arrangements, mix of services, benefit design or processing systems. The cumulative number of reported claims has been provided to comply with FASB accounting standards and is not used by management in its claims analysis. Our cumulative number of reported claims may not be comparable to similar measures reported by other health benefits companies.

The reconciliation of incurred and paid claims development information for the three years ended December 31, 2024, reflected in the tables above, to the consolidated ending balance for medical claims payable included in the consolidated balance sheets, as of December 31, 2024, is as follows:

	Total
Cumulative incurred claims and allocated claim adjustment expenses, net of reinsurance	$ 369,947
Less: Cumulative paid claims and allocated claim adjustment expenses, net of reinsurance	354,380
Net medical claims payable, end of year	15,567
Ceded medical claims payable, end of year	13
Insurance lines other than short duration	256
Liabilities held for sale	(90)
Gross medical claims payable, end of year	$ 15,746

13. Debt

Short-term Borrowings

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, the Federal Home Loan Bank of Atlanta and the Federal Home Loan Bank of New York (collectively, the "FHLBs"). As a member we have the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. At December 31, 2024 and 2023, $365 and $225, respectively, were outstanding under our short-term FHLB borrowings. Outstanding short-term FHLB borrowings at December 31, 2024 had fixed interest rates of 4.43%.

We have a senior revolving credit facility (the "5-Year Facility") with a group of lenders for general corporate purposes. The 5-Year Facility provides credit of up to $4,000 and matures in April 2027. Our ability to borrow under the 5-Year Facility is subject to compliance with certain covenants, including covenants requiring us to maintain a defined debt-to-capital ratio of not more than 60%, subject to increase in certain circumstances set forth in the credit agreement for the 5-Year Facility. As of December 31, 2024, our debt-to-capital ratio, as defined and calculated under the 5-Year Facility, was 43.0%. We do not believe the restrictions contained in our 5-Year Facility covenants materially affect our financial or operating flexibility. As of December 31, 2024, we were in compliance with all of our debt covenants under the 5-Year Facility. There were no amounts outstanding under the 5-Year Facility at any time during the years ended December 31, 2024 or 2023.

We have an authorized commercial paper program of up to $4,000, the proceeds of which may be used for general corporate purposes. At December 31, 2024 and 2023, we had $0 outstanding under our commercial paper program. Beginning in 2023, we reclassified our commercial paper balances from long-term debt to short-term debt as our intent is to not replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year.

Long-term Debt

The carrying value of our long-term debt at December 31, 2024 and 2023 consists of the following:

	2024	2023
Senior unsecured notes:		
3.350%, due 2024	$ —	$ 850
3.500%, due 2024	—	799
2.375%, due 2025	1,250	1,251
5.350%, due 2025	399	399
1.500%, due 2026	749	747
4.500%, due 2026	349	—
4.900%, due 2026	499	496
3.650%, due 2027	1,596	1,595
4.101%, due 2028	1,238	1,236
2.875%, due 2029	822	821
5.150%, due 2029	601	—
2.250%, due 2030	1,075	1,075
4.750%, due 2030	731	—
2.550%, due 2031	971	972
4.950%, due 2031	726	—
4.100%, due 2032	596	595
5.500%, due 2032	635	658
4.750%, due 2033	973	992
5.375%, due 2034	992	—
5.950%, due 2034	335	335
5.200%, due 2035	1,151	—
5.850%, due 2036	397	397
6.375%, due 2037	364	364
5.800%, due 2040	115	114
4.625%, due 2042	860	860
4.650%, due 2043	975	975
4.650%, due 2044	768	768
5.100%, due 2044	548	548
4.375%, due 2047	1,389	1,388
4.550%, due 2048	840	840
3.700%, due 2049	813	813
3.125%, due 2050	988	988
3.600%, due 2051	1,234	1,233
4.550% due 2052	689	689
6.100%, due 2052	742	742
5.125%, due 2053	1,084	1,083
4.850%, due 2054	247	247
5.650%, due 2054	985	—
5.700%, due 2055	1,327	—
5.850% due 2064	789	—
Surplus note:		
9.000%, due 2027	25	25
Total Long-Term Debt	30,867	24,895
Current portion of long-term debt	(1,649)	(1,649)
Long-term debt, less current portion	$ 29,218	$ 23,246

All debt is a direct obligation of Elevance Health, Inc., except for the surplus note and the FHLB borrowings.

We generally issue senior unsecured notes (“Notes”) for long-term borrowing purposes. Certain of these Notes may have a call feature that allows us to redeem the Notes at any time at our option and/or a put feature that allows a Note holder to

redeem the Notes upon the occurrence of both a change in control event and a downgrade of the Notes below an investment grade rating.

On January 15, 2025, we repaid, at maturity, the $1,250 outstanding balance of our 2.375% senior unsecured notes.

On December 1, 2024, we repaid, at maturity, the $850 outstanding balance of our 3.35% senior unsecured notes.

On October 31, 2024, we issued $350 aggregate principal amount of 4.500% Notes due 2026 (the "New 2026 Notes"), $750 aggregate principal amount of 4.750% Notes due 2030 (the "2030 Notes"), $750 aggregate principal amount of 4.950% Notes due 2031 (the "2031 Notes"), $1,200 aggregate principal amount of 5.200% Notes due 2035 (the "2035 Notes"), $1,350 aggregate principal amount of 5.700% Notes due 2055 (the "2055 Notes") and $800 aggregate principal amount of 5.850% Notes due 2064 (the "2064 Notes") under our shelf registration statement. Interest on the New 2026 Notes is payable semi-annually in arrears on April 30 and October 30 of each year, commencing April 30, 2025. Interest on the 2030 Notes, 2035 Notes and 2055 Notes are payable semi-annually in arrears on February 15 and August 15 of each year, commencing February 1, 2025. Interest on the 2031 Notes and 2064 Notes are payable semi-annually in arrears on May 1 and November 1 of each year, commencing May 1, 2025. We used the net proceeds for working capital and general corporate purposes, including, but not limited to, the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

On August 15, 2024, we repaid, at maturity, the $799 outstanding balance of our 3.500% senior unsecured notes.

On May 30, 2024, we issued $600 aggregate principal amount of 5.150% Notes due 2029 (the "2029 Notes"), $1,000 aggregate principal amount of 5.375% Notes due 2034 (the "2034 Notes") and $1,000 aggregate principal amount of 5.650% Notes due 2054 (the "2054 Notes", and, together with the 2029 Notes and the 2034 Notes, the "Notes") under our shelf registration statement. Interest on the Notes is payable semi-annually in arrears on June 15 and December 15 of each year, commencing December 15, 2024. We used the net proceeds for working capital and general corporate purposes, including, but not limited to, the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

On February 8, 2023, we issued $500 aggregate principal amount of 4.900% Notes due 2026 (the "2026 Notes"), $1,000 aggregate principal amount of 4.750% Notes due 2033 (the "2033 Notes") and $1,100 aggregate principal amount of 5.125% Notes due 2053 (the "2053 Notes") under our shelf registration statement. Interest on the 2026 Notes is payable semi-annually in arrears on February 8 and August 8 of each year, commencing August 8, 2023. Interest on the 2033 Notes and 2053 Notes is payable semi-annually in arrears on February 15 and August 15 of each year, commencing August 15, 2023. We used the net proceeds for working capital and general corporate purposes, including, but not limited to, the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

On January 17, 2023, we repaid, at maturity, the $1,000 outstanding balance of our 3.300% senior unsecured notes. On March 15, 2023, we repaid, at maturity, the $500 outstanding balance of our 0.450% senior unsecured notes.

On December 1, 2022, we repaid, at maturity, the $750 outstanding balance of our 2.950% senior unsecured notes.

On November 4, 2022, we issued $400 aggregate principal amount of 5.350% Notes due 2025, $650 aggregate principal amount of 5.500% Notes due 2032 and $750 aggregate principal amount of 6.100% Notes due 2052 under our shelf registration statement. Interest on these notes is payable semi-annually in arrears on April 15 and October 15 of each year, commencing April 15, 2023. We used the net proceeds for working capital and general corporate purposes, such as the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

On May 16, 2022, we repaid, at maturity, the $850 outstanding balance of our 3.125% senior unsecured notes.

On April 29, 2022, we issued $600 aggregate principal amount of 4.100% Notes due 2032 and $700 aggregate principal amount of 4.550% Notes due 2052 under our shelf registration statement. Interest on these notes is payable semi-annually in arrears on May 15 and November 15 of each year, commencing November 15, 2022. We used the net proceeds for working

capital and general corporate purposes, such as the funding of acquisitions, repayment of short-term and long-term debt and the repurchase of our common stock pursuant to our share repurchase program.

Convertible Debentures

On March 15, 2023, we redeemed all of our outstanding senior unsecured convertible debentures due 2042 (the "Debentures"), pursuant to the indenture dated as of October 9, 2012 (the "Indenture") between us and The Bank of New York Mellon Trust Company, N.A., as trustee. The Debentures were redeemed at a redemption price equal to 100% of the principal amount of the Debentures plus accrued and unpaid interest to, but excluding, the date of redemption for cash totaling $5. During the three months ended March 31, 2023, $59 of aggregate principal amount of the Debentures was surrendered for conversion by certain holders in accordance with the terms and conditions of the Indenture. We elected to settle the excess of the principal amount of the conversions with cash for total payments during the three months ended March 31, 2023 of $404.

During the year ended December 31, 2022, $41 aggregate principal amount of the Debentures was surrendered for conversion by certain holders in accordance with the terms and provisions of the Indenture. We elected to settle the excess of the principal amount of the conversion with cash for total payments of $299. We recognized $2 of interest expense related to the Debentures during 2022.

Interest paid on our total outstanding debt during 2024, 2023 and 2022 was $1,239, $1,032, and $878, respectively.

We were in compliance with all applicable covenants under all of our outstanding debt agreements at December 31, 2024 and 2023.

Future maturities of all long-term debt outstanding at December 31, 2024 are as follows: 2025, $1,649; 2026, $1,596; 2027, $1,621; 2028, $1,237; 2029, $1,423 and thereafter, $23,341.

14. Commitments and Contingencies

Litigation and Regulatory Proceedings

We are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court filings the amount of damages being sought, we have noted those alleged damages in the descriptions below.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or probable or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible or probable loss or range of losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings.

With respect to the cases described below, we contest liability and/or the amount of damages in each matter, and we believe we have meritorious defenses. We do not believe the outcome of any known pending or threatened legal actions or proceedings will, in the aggregate, have a material impact on our financial position. However, unanticipated outcomes do sometimes occur, which could result in liabilities in excess of our accruals and could have a material adverse effect on our consolidated financial position or results of operations.

In addition to the lawsuits described below, we are also involved in other pending and threatened litigation of the character incidental to our business and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings ("government actions"). These government actions include routine and special inquiries by and disclosures to state insurance departments, state attorneys general, U.S. Regulatory Agencies, the U.S.

Attorney General and subcommittees of the U.S. Congress. Such government actions could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these government actions individually, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

Blue Cross Blue Shield Antitrust Litigation

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA and Blue Cross and/or Blue Shield licensees (the "Blue plans") across the country. Cases filed in twenty-eight states were consolidated into a single, multi-district proceeding captioned *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the U.S. District Court for the Northern District of Alabama (the "Court"). Generally, the suits allege that the BCBSA and the Blue plans have conspired to horizontally allocate geographic markets through license agreements, best efforts rules that limit the percentage of non-Blue revenue of each plan, restrictions on acquisitions, rules governing the BlueCard® and National Accounts programs and other arrangements in violation of the Sherman Antitrust Act and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers.

The BCBSA and Blue plans approved a settlement agreement and release with the subscriber plaintiffs (the "Subscriber Settlement Agreement"), which agreement required the Court's approval to become effective. The Subscriber Settlement Agreement requires the defendants to make a monetary settlement payment and contains certain terms imposing non-monetary obligations including (i) eliminating the "national best efforts" rule in the BCBSA license agreements (which rule limits the percentage of non-Blue revenue permitted for each Blue plan) and (ii) allowing for some large national employers with self-funded benefit plans to request a bid for insurance coverage from a second Blue plan in addition to the local Blue plan.

In November 2020, the Court issued an order preliminarily approving the Subscriber Settlement Agreement, following which members of the subscriber class were provided notice of the Subscriber Settlement Agreement and an opportunity to opt out of the class. A small number of subscribers submitted valid opt-outs by the opt-out deadline.

In August 2022, the Court issued a final order approving the Subscriber Settlement Agreement (the "Final Approval Order"). The Court amended its Final Approval Order in September 2022, further clarifying the injunctive relief that may be available to subscribers who submitted valid opt-outs. The ultimate amount paid by us under the Subscriber Settlement Agreement was $604.

Four notices of appeal of the Final Approval Order were heard by a panel of the United States Court of Appeals for the Eleventh Circuit (the "Eleventh Circuit") in September 2023, and the Eleventh Circuit affirmed the Court's Final Approval Order approving the Subscriber Settlement Agreement in October 2023. Petitions for rehearing were filed by certain appellants in November 2023 and December 2023 and were denied in January 2024. As a result, the Eleventh Circuit issued a mandate terminating the jurisdiction of the Eleventh Circuit in February 2024. In March 2024, Home Depot, one of the appellants, filed a petition for certiorari to the United States Supreme Court (the "Supreme Court"). On the respondents' request, the Supreme Court granted an extension to respond until May 2024. In April 2024, David Behenna, another appellant, filed a petition for certiorari to the Supreme Court, and the defendants and the subscriber plaintiffs filed briefs in opposition in May 2024. In June 2024, the Supreme Court declined to grant certiorari, exhausting all appellate rights. The Subscriber Settlement Agreement and the defendants' payment and non-monetary obligations under the Subscriber Settlement Agreement became effective in June 2024, with the request for second Blue plan bid provisions effective in September 2024. The funds held in escrow will be distributed in accordance with the Subscriber Settlement Agreement.

A number of follow-on cases involving entities that opted out of the Subscriber Settlement Agreement have been filed. Those actions are: *Alaska Air Group, Inc., et al. v. Anthem, Inc., et al.,* No. 2:21-cv-01209-AMM (N.D. Ala.) *("Alaska Air")*; *JetBlue Airways Corp., et al. v. Anthem, Inc., et al.*, No. 2:22-cv-00558-GMB (N.D. Ala.) *("Jet Blue")*; *Metropolitan Transportation Authority v. Blue Cross and Blue Shield of Alabama et al.*, No. 2:22-cv-00265-RDP (N.D. Ala.) (dismissed without prejudice in June 2023); *Bed Bath & Beyond Inc. v. Anthem, Inc.*, No. 2:22-cv-01256-SGC (N.D. Ala.); *Hoover, et al. v. Blue Cross Blue Shield Association, et al.*, No. 2:22-cv-00261-RDP (N.D. Ala.); and *VHS Liquidating Trust v. Blue Cross of California, et al.*, No. RG21106600 (Cal. Super.) *("VHS")*. In February 2023, the Court denied the defendants' motion to dismiss based on a statute of limitations defense in *Alaska Air* and *Jet Blue*. In September 2023, the California court presiding over the *VHS* case, upheld its prior order granting in part defendants' motion to strike based on the statute of

limitations. We intend to continue to vigorously defend these follow-on cases, which we believe are without merit; however, their ultimate outcome cannot be presently determined.

In October 2020, after the Court lifted the stay as to the provider litigation, provider plaintiffs filed a renewed motion for class certification, which defendants opposed. In March 2021, the Court issued an order terminating the pending motion for class certification until the Court determined the standard of review applicable to the providers' claims. In response to that order, the parties filed renewed standard of review motions, and in June 2021, the parties filed summary judgment motions not critically dependent on class certification. In February 2022, the Court issued orders (i) granting certain defendants' motion for partial summary judgment against the provider plaintiffs who had previously released claims against such defendants, and (ii) granting the provider plaintiffs' motion for partial summary judgment, determining that *Ohio v. American Express Co*. does not affect the standard of review in this case. In August 2022, the Court issued orders (i) granting in part the defendants' motion regarding the antitrust standard of review, holding that for the period of time after the elimination of the "national best efforts" rule, the rule of reason applies to the provider plaintiffs' market allocation conspiracy claims, and (ii) denying the provider plaintiffs' motion for partial summary judgment on the standard of review, reaffirming its prior holding that the provider groups' boycott claims are subject to the rule of reason. In December 2023, the Court denied defendants' motion for summary judgment on providers' damage claims as time-barred and speculative and provider plaintiffs' motion for partial summary judgment on the defendants' single entity defense due to the existence of genuine issues of material fact. In January 2024, the Court issued orders (i) denying defendants' motion for summary judgment on (a) all claims by certain hospital providers and (b) any claims based on the Blue system's rules other than exclusive serviced areas or BlueCard and (ii) denying provider plaintiffs' motion for partial summary judgment on defendants' common law trademark claims.

In the third quarter of 2024, the BCBSA, along with the individually named Blue plans approved a settlement agreement and release (the "Provider Settlement Agreement") with the provider plaintiffs, and in October 2024 the provider plaintiffs filed a motion for preliminary approval with the Court. The Court granted preliminary approval of the provider settlement on December 4, 2024. If finally approved by the Court, the Provider Settlement Agreement will require the defendants to make a monetary settlement payment, our portion of which is estimated to be $666, and will contain certain non-monetary terms including (i) expansion of certain opportunities to contract with providers in contiguous service areas, (ii) certain prompt pay commitments, and (iii) various technological enhancements to the BlueCard program. We recognized our estimated payment obligation under the Provider Settlement Agreement of $666 in September 2024. We recognized this estimated payment obligation as operating expense in the Corporate & Other segment (see Note 20, "Segment Information").

Express Scripts, Inc. Pharmacy Benefit Management Litigation

In March 2016, we filed a lawsuit against Express Scripts, Inc. ("Express Scripts"), our vendor at the time for pharmacy benefit management services, captioned *Anthem, Inc. v. Express Scripts, Inc.*, in the U.S. District Court for the Southern District of New York (the "District Court"). The lawsuit sought to recover over $14,800 in damages for pharmacy pricing that is higher than competitive benchmark pricing under the agreement between the parties (the "ESI Agreement"), over $158 in damages related to operational breaches, as well as various declarations under the ESI Agreement, including that Express Scripts: (i) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms (the "Pricing Claim"); (ii) was required to provide competitive benchmark pricing to us through the term of the ESI Agreement; (iii) has breached the ESI Agreement; and (iv) is required under the ESI Agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination.

Express Scripts disputed our contractual claims and it sought declaratory judgments: (i) regarding the timing of the periodic pricing review under the ESI Agreement, and (ii) that it has no obligation to ensure that we receive any specific level of pricing, that we have no contractual right to any change in pricing under the ESI Agreement and that its sole obligation is to negotiate proposed pricing terms in good faith. In the alternative, Express Scripts claimed that we have been unjustly enriched by its payment of $4,675 at the time we entered into the ESI Agreement. In March 2017, the District Court granted our motion to dismiss Express Scripts' counterclaims for (i) breach of the implied covenant of good faith and fair dealing, and (ii) unjust enrichment with prejudice. After such ruling, Express Scripts' only remaining claims were for breach of contract and declaratory relief. In August 2021, Express Scripts filed a motion for summary judgment, which we opposed. In March 2022, the District Court granted in part and denied in part Express Scripts' motion for summary judgment. The District Court dismissed our declaratory judgment claim, our breach of contract claim for failure to prove damages and most of our operational breach claims. As a result of the summary judgment decision, only two claims remained. Express Scripts filed a second motion for summary judgment in June 2022, challenging our remaining operational breach claims, which the

District Court denied in March 2023. In November 2023, the District Court issued a final judgment ending the lawsuit in the District Court after the parties settled and stipulated to dismiss the only remaining claim that had not been disposed of by the court order or stipulation. In December 2023, we filed a notice of appeal with the United States Court of Appeals for the Second Circuit (the "Second Circuit"), regarding the Pricing Claim. Mediation ordered by the Second Circuit occurred in March 2024 and was unsuccessful. Oral argument before the Second Circuit was held in October 2024. In November 2024, the Court affirmed the trial court's decision dismissing the case. A motion for rehearing was submitted which was denied. The matter is now closed.

Medicare Risk Adjustment Litigation

In March 2020, the U.S. Department of Justice ("DOJ") filed a civil lawsuit against Elevance Health, Inc. in the District Court in a case captioned *United States v. Anthem, Inc*. The DOJ's suit alleges, among other things, that we falsely certified the accuracy of the diagnosis data we submitted to the Centers for Medicare and Medicaid Services ("CMS") for risk-adjustment purposes under Medicare Part C and knowingly failed to delete inaccurate diagnosis codes. The DOJ further alleges that, as a result of these purported acts, we caused CMS to calculate the risk-adjustment payments based on inaccurate diagnosis information, which enabled us to obtain unspecified amounts of payments in Medicare funds in violation of the False Claims Act. The DOJ filed an amended complaint in July 2020, alleging the same causes of action but revising some of its factual allegations. In September 2020, we filed a motion to transfer the lawsuit to the Southern District of Ohio, a motion to dismiss part of the lawsuit, and a motion to strike certain allegations in the amended complaint, all of which the District Court denied in October 2022. In November 2022, we filed an answer. In March 2023, discovery commenced, and an initial case management conference was held in April 2023. Fact discovery is ongoing. In December 2024, the District Court issued a scheduling order setting the deadlines for the completion of fact discovery in August 2025 and April 2026 for the completion of expert discovery. We intend to continue to vigorously defend this suit, which we believe is without merit; however, the ultimate outcome cannot be presently determined.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like Health Maintenance Organizations ("HMOs") and health insurers generally, exclude certain healthcare and other services from coverage under our HMO, Preferred Provider Organizations and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable reimbursement of coverage claims.

Contractual Obligations and Commitments

In September 2024, we extended our agreement with a vendor for information technology infrastructure and related management and support services through June 2029. Our remaining commitment under this agreement is approximately $2,065. We have the ability to terminate the agreement upon the occurrence of certain events, subject to early termination fees.

CarelonRx markets and offers pharmacy services to our affiliated health plan customers throughout the country, as well as to customers outside of the health plans we own. The comprehensive pharmacy services portfolio includes all core pharmacy services, such as home delivery and specialty pharmacies, claims adjudication, formulary management, pharmacy networks, rebate administration, a prescription drug database and member services. CarelonRx delegates certain core pharmacy services to CVS, pursuant to the CVS Agreement, with the current contractual term extending through December 31, 2027. We can elect to have CVS continue to provide services to us for a three-year extension period on the same terms and conditions as in the current CVS Agreement in the event of a termination or non-renewal by either party.

We have financial guarantees related to standby letters of credit and surety bonds related to certain contractual commitments which totaled $912 as of December 31, 2024. We do not believe such obligations will materially affect its financial position, results of operations, or cash flows.

The Company has unfunded loan commitments to certain equity investees of $501 at December 31, 2024. The Company does not believe such obligations will materially affect its financial position, results of operations, or cash flows.

Vulnerability from Concentrations

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash equivalents, investment securities, premium receivables and instruments held through hedging activities. All investment securities are managed by professional investment managers within policies authorized by our Board of Directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. Concentrations of credit risk with respect to premium receivables are limited due to the large number of employer groups that constitute our customer base in the states in which we conduct business. As of December 31, 2024, there were no significant concentrations of financial instruments in a single investee, industry or geographic location.

15. Capital Stock

Stock Incentive Plans

Our Board of Directors has adopted the 2017 Elevance Health Incentive Compensation Plan (the "2017 Incentive Plan") which has been approved by our shareholders. The term of the 2017 Incentive Plan is such that no awards may be granted on or after May 18, 2027. The 2017 Incentive Plan gives authority to the Compensation and Talent Committee of the Board of Directors to make incentive awards to our non-employee directors, employees and consultants, consisting of stock options, stock, restricted stock, restricted stock units, cash-based awards, stock appreciation rights, performance shares and performance units. The 2017 Incentive Plan limits the number of available shares for issuance to 37.5 shares, subject to adjustment as set forth in the 2017 Incentive Plan.

Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the grant date. Stock options vest over three years in equal annual installments and generally have a term of ten years from the grant date.

Certain option grants contain provisions whereby the employee continues to vest in the award subsequent to termination due to retirement. Our attribution method for newly granted awards considers all vesting and other provisions, including retirement eligibility, in determining the requisite service period over which the fair value of the awards will be recognized.

Awards of restricted stock or restricted stock units are issued at the fair value of the stock on the grant date and may also include one or more performance measures that must be met for the award to vest. For restricted stock or restricted stock units without performance measures, the restrictions lapse in three equal annual installments. Restricted stock or restricted stock units with performance measures vest in three-year installments. Performance units issued in 2024 will vest in 2027, based on certain revenue and earnings targets over the three-year period of 2024 to 2026. Performance units issued in 2023 will vest in 2026, based on certain revenue and earnings targets over the three-year period of 2023 to 2025. Performance units issued in 2022 will vest in 2025, based on certain revenue and earnings targets over the three-year period of 2022 to 2024.

For the years ended December 31, 2024, 2023 and 2022, we recognized share-based compensation expense of $191, $289 and $264, respectively, as well as related tax benefits of $47, $73 and $66, respectively.

A summary of stock option activity for the year ended December 31, 2024 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2024	3.0	$ 327.14		
Granted	0.5	499.52		
Exercised	(0.5)	286.33		
Forfeited or expired	(0.1)	459.14		
Outstanding at December 31, 2024	2.9	361.36	5.58	$ 166
Exercisable at December 31, 2024	1.9	300.24	4.41	$ 166

The intrinsic value of options exercised during the years ended December 31, 2024, 2023 and 2022 amounted to $123, $69 and $120, respectively. We recognized tax benefits of $21, $18 and $31 during the years ended December 31, 2024, 2023 and 2022, respectively, from option exercises and disqualifying dispositions. During the years ended December 31, 2024, 2023 and 2022, we received cash of $154, $87 and $120, respectively, from exercises of stock options.

The total fair value of restricted stock awards that vested during the years ended December 31, 2024, 2023 and 2022 was $298, $285 and $261, respectively.

A summary of the status of nonvested restricted stock activity, including restricted stock units and performance units, for the year ended December 31, 2024 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2024	1.1	$ 423.94
Granted	0.6	501.78
Vested	(0.6)	358.21
Forfeited	(0.1)	479.40
Nonvested at December 31, 2024	1.0	478.70

During the year ended December 31, 2024, we granted approximately 0.2 restricted stock units that are contingent upon us achieving certain revenue and earnings targets over the three-year period of 2024 to 2026. These grants have been included in the activity shown above, but will be subject to adjustment at the end of 2026, based on results in the three-year period.

As of December 31, 2024, the total remaining unrecognized compensation expense related to nonvested stock options and restricted stock, including restricted stock units and performance units, amounted to $37 and $203, respectively, which will be amortized over the weighted-average remaining requisite service periods of 9 months and 13 months, respectively.

As of December 31, 2024, there were approximately 10.2 shares of common stock available for future grants under the 2017 Incentive Plan.

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. Expected volatility assumptions used in the binomial lattice model are based on an analysis of implied volatility of publicly traded options on our stock and historical volatility of our stock price. The risk-free interest rate is derived from the U.S. Treasury strip rates at the time of the grant. The expected term of the options was derived from the outputs of the binomial lattice model, which incorporates post-vesting forfeiture assumptions based on an analysis of historical data. The dividend yield was based on our estimate of future dividend yields. Similar groups of employees that have dissimilar exercise behavior are considered separately for valuation purposes. We utilize the multiple-grant approach for recognizing compensation expense associated with each separately vesting portion of the share-based award.

The following weighted-average assumptions were used to estimate the fair values of options granted during the years ended December 31, 2024, 2023 and 2022:

	2024	2023	2022
Risk-free interest rate	4.28 %	3.95 %	1.97 %
Volatility factor	28.00 %	29.00 %	29.00 %
Dividend yield (annual)	1.31 %	1.30 %	1.10 %
Weighted-average expected life (years)	4.40	4.40	5.10

The following weighted-average fair values per share were determined for the years ended December 31, 2024, 2023 and 2022:

	2024	2023	2022
Options granted during the year	$ 134.61	$ 126.90	$ 116.92
Restricted stock awards granted during the year	501.78	467.79	453.70

The binomial lattice option-pricing model requires the input of subjective assumptions including the expected stock price volatility. Because our stock option grants have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in our opinion, existing models do not necessarily provide a reliable single measure of the fair value of our stock option grants.

Employee Stock Purchase Plan

We have registered 14.0 shares of common stock for the Employee Stock Purchase Plan (the "Stock Purchase Plan"), which is intended to provide a means to encourage and assist employees in acquiring a stock ownership interest in Elevance Health. Pursuant to the terms of the Stock Purchase Plan, an eligible employee is permitted to purchase no more than $25,000 (actual dollars) worth of stock in any calendar year, based on the fair value of the stock at the end of each plan quarter. Employees become participants by electing payroll deductions from 1% to 15% of gross compensation. Once purchased, the stock is accumulated in the employee's investment account. The Stock Purchase Plan allows participants to purchase shares of our common stock at a discounted price per share of 90% of the fair value of a share of common stock on the lower of the first or last trading day of the plan quarter purchase period. The Stock Purchase Plan discount was recognized as compensation expense for the year ended December 31, 2024, based on GAAP guidance. During the years ended December 31, 2024, 2023 and 2022, we issued 0.2, 0.1 and 0.1 shares, respectively, under the Stock Purchase Plan, and we received cash of $65, $65 and $62, respectively, for such shares. As of December 31, 2024, 4.0 shares were available for issuance under the Stock Purchase Plan.

Use of Capital and Stock Repurchase Program

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

A summary of the cash dividend activity for the years ended December 31, 2024 and 2023 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
Year ended December 31, 2024				
January 23, 2024	March 8, 2024	March 22, 2024	$ 1.63	$ 379
April 16, 2024	June 10, 2024	June 25, 2024	1.63	378
July 16, 2024	September 10, 2024	September 25, 2024	1.63	378
October 15, 2024	December 5, 2024	December 20, 2024	1.63	373
Year ended December 31, 2023				
January 24, 2023	March 10, 2023	March 24, 2023	$ 1.48	$ 351
April 18, 2023	June 9, 2023	June 23, 2023	1.48	350
July 18, 2023	September 8, 2023	September 22, 2023	1.48	348
October 17, 2023	December 6, 2023	December 21, 2023	1.48	346

On January 22, 2025, our Audit Committee declared a quarterly cash dividend to shareholders of $1.71 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 25, 2025 to the shareholders of record as of March 10, 2025.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On October 15, 2024, our Audit Committee, pursuant to authorization granted by the Board of Directors, authorized an $8,000 increase to the common stock repurchase program. No duration has been placed on our common stock repurchase program, and we reserve the right to discontinue the program at any time. We intend to utilize this authorization over a multi-year period, subject to market and industry conditions. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are affected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary, as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings.

A summary of common stock repurchases for the years ended December 31, 2024 and 2023 is as follows:

	Years Ended December 31	
	2024	2023
Shares repurchased	6.7	5.8
Average price per share	$ 435.32	$ 463.53
Aggregate cost	$ 2,900	$ 2,676
Authorization remaining at end of year	$ 9,300	$ 4,200

We expect to utilize the remaining authorized amount over a multi-year period, subject to market and industry conditions.

For additional information regarding the use of capital for debt security repurchases, see Note 13, "Debt."

16. Accumulated Other Comprehensive (Loss) Income

A reconciliation of the components of accumulated other comprehensive (loss) income at December 31, 2024, 2023, and 2022 is as follows:

	2024	2023	2022
Net unrealized investment gains:			
Beginning of year balance	$ (632)	$ (1,755)	$ 494
Other comprehensive (loss) income before reclassifications, net of tax benefit (expense) of $44, $(218), and $926, respectively	(153)	760	(2,614)
Amounts reclassified from accumulated other comprehensive income, net of tax expense of $(82), $(113), and $(94), respectively	256	357	354
Other comprehensive income (loss)	103	1,117	(2,260)
Other comprehensive income attributable to noncontrolling interests, net of tax benefit (expense) of $1, $1, and $(3), respectively	6	6	11
End of year balance	(523)	(632)	(1,755)
Non-credit components of impairments on investments:			
Beginning of year balance	(3)	(3)	—
Other comprehensive income (loss), net of tax expense of $(1), $0, and $0, respectively	1	—	(3)
End of year balance	(2)	(3)	(3)
Net cash flow hedges:			
Beginning of year balance	(211)	(229)	(239)
Other comprehensive income, net of tax benefit (expense) of $(4), $6, and $(6), respectively	4	18	10
End of year balance	(207)	(211)	(229)
Pension and other benefits:			
Beginning of year balance	(459)	(499)	(429)
Other comprehensive income (loss), net of tax expense of $0, $(39), and $(23), respectively	60	40	(70)
End of year balance	(399)	(459)	(499)
Future policy benefits:			
Beginning of year balance	10	13	(19)
Other comprehensive (loss) income, net of tax benefit (expense) of $1, $1, and $(10), respectively	(2)	(3)	32
End of year balance	8	10	13
Foreign currency translation adjustments:			
Beginning of year balance	(18)	(17)	(4)
Other comprehensive loss, net of tax benefit of $0, $1, and $6	(6)	(1)	(13)
End of year balance	(24)	(18)	(17)
Total:			
Total beginning of year accumulated other comprehensive loss	(1,313)	(2,490)	(197)
Total other comprehensive income (loss), net of tax benefit (expense) of $(42), $(362), and $799, respectively	160	1,171	(2,304)
Total other comprehensive income attributable to noncontrolling interests, net of tax benefit (expense) of $1, $1, and $(3), respectively	6	6	11
Total end of year accumulated other comprehensive loss	$ (1,147)	$ (1,313)	$ (2,490)

17. Reinsurance

We reinsure certain risks with other companies and assume risk from other companies. We remain primarily liable to policyholders under ceded insurance contracts and are contingently liable for amounts recoverable from reinsurers in the event that such reinsurers do not meet their contractual obligations.

A summary of direct, assumed and ceded premiums earned for the years ended December 31, 2024, 2023 and 2022 is as follows:

	2024	2023	2022
Direct	$ 139,479	$ 136,927	$ 127,788
Assumed	4,753	5,988	5,505
Ceded	(66)	(61)	(64)
Net premiums	$ 144,166	$ 142,854	$ 133,229
Percentage—assumed to net premiums	3.3 %	4.2 %	4.1 %

The difference between written premiums and earned premiums is immaterial in each of the years presented above.

A summary of net premiums earned by segment (see Note 20, “Segment Information”) for the years ended December 31, 2024, 2023 and 2022 is as follows:

	2024	2023	2022
Reportable segments:			
Health Benefits	$ 142,668	$ 141,515	$ 131,964
Carelon Services	2,630	1,679	1,499
Eliminations	(1,132)	(340)	(234)
Net premiums	$ 144,166	$ 142,854	$ 133,229

The effect of reinsurance on benefit expense for the years ended December 31, 2024, 2023 and 2022 is as follows:

	2024	2023	2022
Direct	$ 123,602	$ 119,409	$ 112,061
Assumed	4,021	4,984	4,633
Ceded	(56)	(63)	(52)
Net benefit expense	$ 127,567	$ 124,330	$ 116,642

18. Leases

We lease office space and certain computer and related equipment using noncancelable operating leases. Our leases have remaining lease terms of 1 year to 11 years.

The information related to our leases is as follows:

	Balance Sheet Location	December 31, 2024	December 31, 2023
Operating Leases			
ROU assets	Other noncurrent assets	$ 567	$ 584
Lease liabilities, current	Other current liabilities	153	164
Lease liabilities, noncurrent	Other noncurrent liabilities	658	685

	Years Ended December 31		
	2024	2023	2022
Lease Expense			
Operating lease expense	$ 147	$ 155	$ 143
Short-term and variable lease expense	47	43	35
Sublease income	(6)	(5)	(3)
Total lease expense	$ 188	$ 193	$ 175

Our activities as disclosed in Note 4, "Business Optimization Initiatives," include reducing our office space footprint. As a result, we performed an interim impairment test during the years ended December 31, 2024, 2023 and 2022, and recorded impairment charges of $17, $23 and $34, respectively, for impairment and abandonment of ROU assets which are included in the operating lease expense shown above.

	Years Ended December 31	
	2024	2023
Other information		
Operating cash paid for amounts included in the measurement of lease liabilities, operating leases	$ 202	$ 206
ROU assets obtained in exchange for new lease liabilities, operating leases	$ 44	$ 59
Weighted average remaining lease term in years, operating leases	6	6
Weighted average discount rate, operating leases	3.96 %	3.66 %

At December 31, 2024, future lease payments for noncancelable operating leases with initial or remaining terms of one year or more are as follows:

2025	$ 184
2026	154
2027	127
2028	112
2029	100
Thereafter	209
Total future minimum payments	886
Less imputed interest	(75)
Total lease liabilities	$ 811

19. Shareholders' Earnings per Share

The denominator for basic and diluted shareholders' earnings per share at December 31, 2024, 2023 and 2022 is as follows:

	2024	2023	2022
Denominator for basic shareholders' earnings per share—weighted-average shares	231.7	235.9	240.0
Effect of dilutive securities—employee stock options, non-vested restricted stock awards and convertible debentures	1.2	1.5	2.8
Denominator for diluted shareholders' earnings per share	232.9	237.4	242.8

During the years ended December 31, 2024, 2023 and 2022, weighted-average shares related to certain stock options of 0.7, 0.8 and 0.4, respectively, were excluded from the denominator for diluted shareholders' earnings per share because the stock options were anti-dilutive.

During each of the years ended December 31, 2024, 2023 and 2022, we issued approximately 0.2 restricted stock units, of which vesting was contingent upon us meeting certain earnings targets. Contingent restricted stock units are excluded from the denominator for diluted shareholders' earnings per share and are included only if and when the contingency is met. The 2024 contingent restricted stock units are being measured over the three-year period of 2024 through 2026, the 2023 contingent restricted stock units are being measured over the three-year period of 2023 through 2025 and the 2022 contingent restricted stock units are being measured over the three year period of 2022 through 2024. Contingent restricted stock units generally vest in March of the year following each measurement period.

20. Segment Information

We report our results of operations in the following four reportable segments: Health Benefits, CarelonRx, Carelon Services and Corporate & Other. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S. and Puerto Rico.

Our Health Benefits segment offers a comprehensive suite of health plans and services to our Individual, Employer Group risk-based, Employer Group fee-based, BlueCard®, Medicare, Medicaid and FEP® members. The Health Benefits segment offers health products on a full-risk basis; provides a broad array of administrative managed care services to our fee-based customers; and provides a variety of specialty and other insurance products and services such as stop loss, dental, vision and supplemental health insurance benefits.

Our CarelonRx segment includes our pharmacy services business. CarelonRx markets and offers pharmacy services to our affiliated health plan customers, as well as to external customers outside of the health plans we own. CarelonRx offers a comprehensive pharmacy services portfolio, which includes all core pharmacy services, such as home delivery and specialty pharmacies, claims adjudication, formulary management, pharmacy networks, rebate administration, a prescription drug database and member services, as well as infusion services and injectable therapies.

Our Carelon Services segment integrates physical, behavioral, pharmacy, and social services with the aim of delivering whole health affordably by offering a broad array of healthcare related services and capabilities to internal and external customers through our Carelon Health and Carelon Insights businesses. Carelon promotes affordability by managing complex areas of the healthcare system, leveraging data and insights to ensure members receive safe, appropriate, high-quality care and providers are reimbursed accurately and timely. Our approach to cost management relies on capabilities including provider enablement, value-based networks, member engagement, and utilization management. Our care delivery services primarily target serving chronic and complex populations by providing personalized care in the home and virtually. As a part of Carelon Health, we completed our acquisition of CareBridge at the end of 2024, which provides virtual care to complex Medicaid and Medicare patients and supports plans in managing home and community-based services.

Our Corporate & Other segment includes our businesses that do not individually meet the quantitative threshold for an operating segment, as well as corporate expenses not allocated to our other reportable segments.

We define operating revenues to include premiums, product revenue and service fees. Operating revenues are derived from premiums and fees received, primarily from the sale and administration of health benefits and pharmacy products and services. Operating gain is calculated as total operating revenue less benefit expense, cost of products sold and operating expense.

Affiliated operating revenues represent revenues or costs for services provided to our subsidiaries by CarelonRx and Carelon Services, in addition to certain administrative and other services provided by our international businesses, which are recorded at cost or management's estimate of fair market value. These affiliated operating revenues are eliminated in our consolidated financial statements. For segment reporting, we present all capitation risk arrangements on a gross basis; therefore, eliminations also include adjustments for capitated risk arrangements that are recognized on a net basis under GAAP.

Through our participation in various federal government programs, we generated approximately 31%, 29% and 28% of our total consolidated revenues from agencies of the U.S. government for the year ended December 31, 2024, 2023 and 2022, respectively. The majority of these revenues are contained in our Health Benefits segment.

The accounting policies of the segments are consistent with those described in the summary of significant accounting policies in Note 2, "Basis of Presentation and Significant Accounting Policies," except that all capitation risk arrangements are reported on a gross basis with an adjustment included in eliminations for capitated risk arrangements that are presented on a net basis under GAAP.

Our chief operating decision maker (the "CODM") is our Chief Executive Officer. The CODM assesses the performance of our reportable segments based on operating gain or loss as defined above. The CODM evaluates net investment income, net gains (losses) on financial instruments, interest expense, depreciation and amortization expense, income taxes and assets, liabilities and equity on a consolidated basis, as these items are managed in a corporate shared service environment and are not the responsibility of segment operating management.

The CODM uses operating gain or loss, developed during the annual budget process, and updated during the periodic forecasting process, as a basis to assess performance and allocate operating and capital resources to each segment.

Financial data by reportable segment for the years ended December 31, 2024, 2023 and 2022 is as follows:

	Health Benefits	Carelon			Corporate & Other	Eliminations	Total
		CarelonRx	Carelon Services	Total			
Year Ended December 31, 2024							
Premiums	$ 142,668	$ —	$ 2,630	$ 2,630	$ —	$ (1,132)	$ 144,166
Product revenue	—	22,630	—	22,630	—	—	22,630
Service fees	7,607	5	790	795	6	—	8,408
Operating revenue - unaffiliated	150,275	22,635	3,420	26,055	6	(1,132)	175,204
Operating revenue - affiliated	—	13,326	14,541	27,867	303	(28,170)	—
Operating revenue - total	$ 150,275	$ 35,961	$ 17,961	$ 53,922	$ 309	$ (29,302)	$ 175,204
Benefit expense	$ 126,703	$ —	$ 14,388	$ 14,388	$ 19	$ (13,543)	$ 127,567
Cost of products sold	—	32,978	—	32,978	—	(13,228)	19,750
Operating expense	17,329	811	2,856	3,667	1,560	(2,531)	20,025
Operating gain (loss)	$ 6,243	$ 2,172	$ 717	$ 2,889	$ (1,270)	$ —	$ 7,862
Year Ended December 31, 2023							
Premiums	$ 141,515	$ —	$ 1,679	$ 1,679	$ —	$ (340)	$ 142,854
Product revenue	—	19,452	—	19,452	—	—	19,452
Service fees	7,056	6	813	819	28	—	7,903
Operating revenue - unaffiliated	148,571	19,458	2,492	21,950	28	(340)	170,209
Operating revenue - affiliated	—	14,377	11,655	26,032	451	(26,483)	—
Operating revenue - total	$ 148,571	$ 33,835	$ 14,147	$ 47,982	$ 479	$ (26,823)	$ 170,209
Benefit expense	$ 123,705	$ —	$ 10,610	$ 10,610	$ 35	$ (10,020)	$ 124,330
Cost of products sold	—	31,588	—	31,588	—	(14,295)	17,293
Operating expense	17,978	272	2,857	3,129	1,488	(2,508)	20,087
Operating gain (loss)	$ 6,888	$ 1,975	$ 680	$ 2,655	$ (1,044)	$ —	$ 8,499
Year Ended December 31, 2022							
Premiums	$ 131,964	$ —	$ 1,499	$ 1,499	$ —	$ (234)	$ 133,229
Product revenue	—	14,978	—	14,978	—	—	14,978
Service fees	6,520	—	889	889	44	—	7,453
Operating revenue - unaffiliated	138,484	14,978	2,388	17,366	44	(234)	155,660
Operating revenue - affiliated	—	13,548	10,472	24,020	355	(24,375)	—
Operating revenue - total	$ 138,484	$ 28,526	$ 12,860	$ 41,386	$ 399	$ (24,609)	$ 155,660
Benefit expense	$ 115,869	$ —	$ 9,667	$ 9,667	$ 39	$ (8,933)	$ 116,642
Cost of products sold	—	26,544	—	26,544	—	(13,509)	13,035
Operating expense	16,593	114	2,658	2,772	502	(2,167)	17,700
Operating gain (loss)	$ 6,022	$ 1,868	$ 535	$ 2,403	$ (142)	$ —	$ 8,283

A reconciliation of reportable segments' operating revenue to the amounts of total revenues included in our consolidated statements of income for the years ended December 31, 2024, 2023 and 2022 is as follows:

	2024	2023	2022
Reportable segments' operating revenues	$ 175,204	$ 170,209	$ 155,660
Net investment income	2,051	1,825	1,485
Net losses on financial instruments	(445)	(694)	(550)
Gain on sale of business	201	—	—
Total revenues	$ 177,011	$ 171,340	$ 156,595

A reconciliation of reportable segments' operating gain to income before income tax expense included in our consolidated statements of income for the years ended December 31, 2024, 2023 and 2022 is as follows:

	2024	2023	2022
Income before income tax expense	$ 7,904	$ 7,715	$ 7,600
Net investment income	(2,051)	(1,825)	(1,485)
Net losses on financial instruments	445	694	550
Gain on sale of business	(201)	—	—
Interest expense	1,185	1,030	851
Amortization of other intangible assets	580	885	767
Reportable segments' operating gain	$ 7,862	$ 8,499	$ 8,283

21. Related Party Transactions

We have an equity investment in APC Passe, LLC, which offers Medicaid products in Arkansas. During the years ended December 31, 2024, 2023 and 2022, in the normal course of business, we assumed premiums of $490, $481 and $501, respectively, from APC Passe, LLC, which is included in our total assumed premiums (see Note 17, "Reinsurance").

In January 2023, we made an equity investment that resulted in our minority interest ownership of Liberty Dental. During the years ended December 31, 2024 and 2023, in the normal course of business, Liberty Dental provided administrative services to our Medicare Advantage members under a capitated arrangement amounting to $519 and $426, respectively, reported in benefit expense.

22. Statutory Information

The majority of our insurance and HMO subsidiaries report their accounts in conformity with accounting practices prescribed or permitted by state insurance regulatory authorities, commonly referred to as statutory accounting, which vary in certain respects from GAAP. However, certain of our insurance and HMO subsidiaries, including Blue Cross of California, Blue Cross of California Partnership Plan, Inc., Carelon Behavioral Health of California, Inc. and Carelon Health of California, Inc. are regulated by the California Department of Managed Health Care ("DMHC") and report their accounts in conformity with GAAP (these entities are collectively referred to as the "DMHC regulated entities"). Typical differences of GAAP reporting as compared to statutory reporting are the recognition of all assets including those that are non-admitted for statutory purposes and recognition of all deferred tax assets without regard to statutory limits. The National Association of Insurance Commissioners (the "NAIC") developed a codified version of the statutory accounting principles, designed to foster more consistency among the states for accounting guidelines and reporting. Prescribed statutory accounting practices are set forth in a variety of publications of the NAIC as well as state laws, regulations and general administrative rules.

Our statutory basis insurance and HMO subsidiaries are subject to risk-based capital ("RBC") requirements. RBC is a method developed by the NAIC to determine the minimum amount of statutory capital appropriate for an insurance company or HMO to support its overall business operations in consideration of its size and risk profile. The formula for determining the amount of RBC specifies various factors, weighted based on the perceived degree of risk, which are applied to certain financial balances and financial activity. Below minimum RBC requirements are classified within certain levels, each of

which requires specified corrective action. Additionally, the DMHC regulated entities are subject to capital and solvency requirements as prescribed by the DMHC. As of December 31, 2024 and 2023, all of our regulated subsidiaries exceeded the minimum applicable mandatory RBC requirements and/or capital and solvency requirements of their applicable governmental regulator.

The statutory RBC necessary to satisfy regulatory requirements of our statutory basis insurance and HMO subsidiaries was approximately $8,100 and $7,800 as of December 31, 2024 and 2023, respectively. The tangible net equity required for the DMHC regulated entities was approximately $970 and $950 as of December 31, 2024 and 2023, respectively. Statutory-basis capital and surplus of our insurance and HMO subsidiaries and capital and surplus of our other regulated subsidiaries, excluding the DMHC regulated entities, was $18,668 and $19,808 at December 31, 2024 and 2023, respectively. GAAP equity of the DMHC regulated entities was $3,817 and $3,975 at December 31, 2024 and 2023, respectively.

Our ability to pay dividends and credit obligations is significantly dependent on receipt of dividends from our subsidiaries. The payment of dividends to us by our insurance and HMO subsidiaries without prior approval of the insurance departments of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective state insurance departments or the DMHC. During 2024, our insurance and HMO subsidiaries paid aggregate cash dividends of $6,322 to the parent company, including cash dividends which required prior approval from regulatory authorities. We currently estimate that approximately $2,700 of dividends will be paid to the parent company in 2025.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE.

There have been no changes in or disagreements with our independent registered public accounting firm on accounting or financial disclosures.

ITEM 9A. CONTROLS AND PROCEDURES.

Evaluation of Disclosure Controls and Procedures

We carried out an evaluation as of December 31, 2024, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as defined in Rule 13a-15(e) of the Exchange Act. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective in timely alerting them to material information relating to us (including our consolidated subsidiaries) required to be disclosed in our reports under the Exchange Act. In addition, based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosures.

Management's Report on Internal Control over Financial Reporting

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, of Elevance Health, Inc. (the "Company") is responsible for establishing and maintaining effective internal control over financial reporting ("Internal Control"), as such term is defined in the Exchange Act. The Company's Internal Control is designed to provide reasonable assurance regarding the reliability of the Company's financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP. The Company's Internal Control includes those policies and procedures that (i) pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the financial statements.

Because of inherent limitations in any Internal Control, no matter how well designed, misstatements due to error or fraud may occur and not be detected. Accordingly, even effective Internal Control can provide only reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, assessed the effectiveness of the Company's Internal Control as of December 31, 2024. Management's assessment was based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

The Company completed its acquisitions of Paragon Healthcare, Inc., Centers Plan for Healthy Living LLC, Centers for Specialty Care Group IPA, LLC, and RSV QOZB LTSS, Inc. and certain of its affiliated entities in 2024. As permitted by the U.S. Securities and Exchange Commission, management's assessment as of December 31, 2024 did not include the Internal Control of these acquired entities, which are included in the Company's consolidated financial statements as of December 31, 2024. Such operations of Paragon Healthcare, Inc., Centers Plan for Health Living LLC, Centers for Specialty Care Group IPA, LLC, and RSV QOZB LTSS, Inc. and certain of its affiliated entities constituted 5% of the Company's total assets and 11% of the Company's net assets, respectively, as of December 31, 2024 and 1% of the Company's total revenues and 0% of the Company's net income, respectively, for the year then ended.

Based on management's assessment, management has concluded that the Company's Internal Control was effective as of December 31, 2024 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP.

Ernst & Young LLP, the Company's independent registered public accounting firm, has audited the consolidated financial statements of the Company for the year ended December 31, 2024, and has also issued an audit report dated February 20, 2025, on the effectiveness of the Company's Internal Control as of December 31, 2024, which is included in this Annual Report on Form 10-K.

/S/ GAIL K. BOUDREAUX	/S/ MARK B. KAYE
President and Chief Executive Officer	Executive Vice President and Chief Financial Officer

Changes in Internal Control over Financial Reporting

There have been no changes in our internal control over financial reporting that occurred during the three months ended December 31, 2024 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Elevance Health, Inc.

Opinion on Internal Control Over Financial Reporting

We have audited Elevance Health, Inc.'s internal control over financial reporting as of December 31, 2024, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Elevance Health, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2024, based on the COSO criteria.

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Paragon Healthcare, Inc., Centers Plan for Healthy Living LLC, Centers for Specialty Care Group IPA, LLC, and RSV QOZB LTSS, Inc. and certain affiliated entities, which are included in the 2024 consolidated financial statements of the Company and constituted 5% and 11% of total and net assets, respectively, as of December 31, 2024 and 1% and 0% of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Paragon Healthcare, Inc., Centers Plan for Healthy Living LLC, Centers for Specialty Care Group IPA, LLC, and RSV QOZB LTSS, Inc. and certain affiliated entities.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Elevance Health, Inc. as of December 31, 2024 and 2023, the related consolidated statements of income, comprehensive income, cash flows and shareholders' equity for each of the three years in the period ended December 31, 2024, and the related notes and financial statement schedule listed in the Index at Item 15(c) and our report dated February 20, 2025 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Indianapolis, Indiana
February 20, 2025

ITEM 9B. OTHER INFORMATION.

Rule 10b5-1 Trading Plans

During the three months ended December 31, 2024, none of our directors or officers (as defined in Rule-1(f) of the Exchange Act) adopted, modified or terminated a "Rule 10b5-1 trading arrangement" or "non-Rule 10b5-1 trading arrangement", as each term is defined in Item 408 of Regulation S-K.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS.

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE.

We have adopted an insider trading policy governing the purchase, sale and other dispositions of our securities that applies to all directors, officers and employees. We also follow procedures for the repurchase of our securities. We believe our insider trading policy and repurchase procedures are reasonably designed to promote compliance with insider trading laws, rules and regulations and listing standards of the New York Stock Exchange applicable to us. A copy of our insider trading policy is filed as Exhibit 19.1 to this Form 10-K.

The information required by this Item concerning our Executive Officers is included in Part I, Item 1, "Business - *Information about our Executive Officers.*"

The information required by this Item concerning our Directors and nominees for Director, information about our Audit Committee members and financial expert(s), disclosure of any delinquent filers under Section 16(a) of the Exchange Act and our Code of Conduct is incorporated herein by reference from our definitive Proxy Statement for our 2025 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 11. EXECUTIVE COMPENSATION.

The information required by this Item concerning remuneration of our Executive Officers and Directors, material transactions involving such Executive Officers and Directors and Compensation Committee interlocks, as well as the Compensation and Talent Committee Report and the CEO pay ratio are incorporated herein by reference from our definitive Proxy Statement for our 2025 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS.

Securities Authorized for Issuance under Equity Compensation Plans

Securities authorized for issuance under our equity compensation plans as of December 31, 2024 are as follows:

Plan Category[1]	Number of securities to be issued upon exercise of outstanding options, warrants and rights[2] (a)	Weighted-average exercise price of outstanding options, warrants and rights[3] (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))[4] (c)
Equity compensation plans approved by shareholders as of December 31, 2024	**4,415,217**	**$361.36**	**14,215,732**

1 We have no equity compensation plans pursuant to which awards may be granted in the future that have not been approved by shareholders.

2 Includes shares that may be issued under the Elevance Health Incentive Compensation Plan and the 2017 Elevance Health Incentive Compensation Plan pursuant to the following outstanding awards: 2,863,293 stock options, 500,096 unvested restricted stock units, and 1,051,828 performance stock units (assuming that the outstanding performance stock units are earned at the maximum award level).

3 Represents the weighted average exercise price of outstanding stock options. Does not take into consideration outstanding restricted stock units or performance stock units, which, once vested, may be converted into shares of our common stock on a one-for-one basis upon distribution at no additional cost.

4 Excludes securities reflected in the first column, "Number of securities to be issued upon exercise of outstanding options, warrants and rights." Includes 10,204,347 shares of common stock available for issuance as stock options, restricted stock awards, performance stock awards, performance awards and stock appreciation rights under the 2017 Elevance Health Incentive Compensation Plan at December 31, 2024. Includes 4,011,385 shares of common stock available for issuance under the Stock Purchase Plan at December 31, 2024.

The information required by this Item concerning the stock ownership of management and five percent beneficial owners is incorporated herein by reference from our definitive Proxy Statement for our 2025 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE.

The information required by this Item concerning certain relationships and related person transactions and Director independence is incorporated herein by reference from our definitive Proxy Statement for our 2025 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES.

The information required by this Item concerning principal accountant fees and services is incorporated herein by reference from our definitive Proxy Statement for our 2025 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES.

(a) 1. Financial Statements:

The following consolidated financial statements of the Company are set forth in Part II, Item 8:

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets as of December 31, 2024 and 2023

Consolidated Statements of Income for the years ended December 31, 2024, 2023, and 2022

Consolidated Statements of Comprehensive Income for the years ended December 31, 2024, 2023, and 2022

Consolidated Statements of Cash Flows for the years ended December 31, 2024, 2023 and 2022

Consolidated Statements of Shareholders' Equity for the years ended December 31, 2024, 2023 and 2022

Notes to Consolidated Financial Statements

2. Financial Statement Schedule:

The following financial statement schedule of the Company is included in Item 15(c):

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore, have been omitted.

3. Exhibits required to be filed as part of this report:

Exhibit Number	Exhibit
3.1	Amended and Restated Articles of Incorporation of the Company, as amended and restated effective June 27, 2022, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on June 28, 2022.
3.2	Bylaws of the Company, as amended effective October 4, 2023, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on October 5, 2023.
4.1	Indenture, dated as of December 9, 2004, between the Company and The Bank of New York Trust Company, N.A., as trustee, including the Form of the Company's 5.950% Notes due 2034, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on December 15, 2004.
4.2	Indenture, dated as of January 10, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. (formerly known as The Bank of New York Trust Company, N.A.), as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on January 11, 2006.
(a)	Form of 5.85% Notes due 2036, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on January 11, 2006.
(b)	Form of 6.375% Notes due 2037, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on June 8, 2007.
(c)	Form of 5.800% Notes due 2040, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2010.
(d)	Form of 4.625% Notes due 2042, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 7, 2012.
(e)	Form of 4.650% Notes due 2043, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on September 10, 2012.

Exhibit Number	Exhibit
	(f) Form of 5.100% Notes due 2044, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on July 31, 2013.
	(g) Form of 4.650% Notes due 2044, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on August 12, 2014.
	(h) Form of 4.850% Notes due 2054, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on August 12, 2014.
4.3	Subordinated Indenture, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on May 12, 2015.
4.4	Indenture dated as of November 21, 2017 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(a) Form of 3.650% Notes due 2027, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(b) Form of 4.375% Notes due 2047, incorporated by reference to Exhibit 4.6 to the Company's Current Report on Form 8-K filed on November 21, 2017.
	(c) Form of 4.101% Notes due 2028, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on March 2, 2018.
	(d) Form of 4.550% Notes due 2048, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on March 2, 2018.
	(e) Form of 2.375% Notes due 2025, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on September 9, 2019.
	(f) Form of 2.875% Notes due 2029, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on September 9, 2019.
	(g) Form of 3.700% Notes due 2049, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on September 9, 2019.
	(h) Form of 2.250% Notes due 2030, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 5, 2020.
	(i) Form of 3.125% Notes due 2050, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 5, 2020.
	(j) Form of 1.500% Notes due 2026, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on March 17, 2021.
	(k) Form of 2.550% Notes due 2031, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on March 17, 2021.
	(l) Form of 3.600% Notes due 2051, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on March 17, 2021.
	(m) Form of 4.100% Notes due 2032, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on April 29, 2022.
	(n) Form of 4.550% Notes due 2052, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on April 29, 2022.
	(o) Form of 5.350% Notes due 2025, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on November 4, 2022.
	(p) Form of 5.500% Notes due 2032, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on November 4, 2022.

Exhibit Number		Exhibit
	(q)	Form of 6.100% Notes due 2052, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on November 4, 2022.
	(r)	Form of 4.900% Notes due 2026, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on February 8, 2023.
	(s)	Form of 4.750% Notes due 2033, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on February 8, 2023.
	(t)	Form of 5.125% Notes due 2053, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on February 8, 2023.
	(u)	Form of 5.150% Notes due 2029, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 30, 2024.
	(v)	Form of 5.375% Notes due 2034, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 30, 2024.
	(w)	Form of 5.650% Notes due 2054, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on May 30, 2024.
	(x)	Form of 4.500% Notes due 2026, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on October 31, 2024.
	(y)	Form of 4.750% Notes due 2030, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on October 31, 2024.
	(z)	Form of 4.950% Notes due 2031, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on October 31, 2024.
	(aa)	Form of 5.200% Notes due 2035, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on October 31, 2024.
	(bb)	Form of 5.700% Notes due 2055, incorporated by reference to Exhibit 4.6 to the Company's Current Report on Form 8-K filed on October 31, 2024.
	(cc)	Form of 5.850% Notes due 2064, incorporated by reference to Exhibit 4.7 to the Company's Current Report on Form 8-K filed on October 31, 2024.
4.5		Upon the request of the Securities and Exchange Commission, the Company will furnish copies of any other instruments defining the rights of holders of long-term debt of the Company or its subsidiaries.
4.6		Description of the Company's Securities Registered Pursuant to Section 12 of the Exchange Act, incorporated by reference to Exhibit 4.7 to the Company's Annual Report on Form 10-K for the year ended December 31, 2022.
10.1	*	Elevance Health Incentive Compensation Plan, as amended and restated effective June 28, 2022, incorporated by reference to Exhibit 10.1 to the Company's Annual Report on Form 10-K for the year ended December 31, 2022.
	(a)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2016 and 2017, incorporated by reference to Exhibit 10.2(s) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
10.2	*	2017 Elevance Health Incentive Compensation Plan, as amended and restated effective June 28, 2022, incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2022.
	(a)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2018, incorporated by reference to Exhibit 10.2(d) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018.
	(b)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement commencing July 2018, incorporated by reference to Exhibit 10.2(h) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.

Exhibit Number		Exhibit
	(c)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2019, incorporated by reference to Exhibit 10.2(l) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2019.
	(d)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2020, incorporated by reference to Exhibit 10.2(l) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2020.
	(e)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2021, incorporated by reference to Exhibit 10.2(m) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2021.
	(f)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2021, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2021.
	(g)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2021, incorporated by reference to Exhibit 10.2(o) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2021.
	(h)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2022, as amended and restated effective June 28, 2022, incorporated by reference to Exhibit 10.2(l) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2022.
	(i)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2022, as amended and restated effective June 28, 2022, incorporated by reference to Exhibit 10.2(m) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2022.
	(j)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2022, as amended and restated effective June 28, 2022, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2022.
	(k)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2023, incorporated by reference to Exhibit 10.2(o) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2023.
	(l)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2023, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2023.
	(m)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2023, incorporated by reference to Exhibit 10.2(q) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2023.
	(n)	Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2024, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2024.
	(o)	Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2024, incorporated by reference to Exhibit 10.2(q) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2024.
	(p)	Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2024, incorporated by reference to Exhibit 10.2(r) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2024.
10.3	*	Elevance Health Comprehensive Nonqualified Deferred Compensation Plan, as amended and restated effective January 1, 2024, incorporated by reference to Exhibit 10.3 to the Company's Annual Report on Form 10-K for the year ended December 31, 2023.
10.4	*	Elevance Health Executive Agreement Plan, as amended and restated effective March 1, 2024, incorporated by reference to Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2024.

Exhibit Number		Exhibit
10.5	*	Elevance Health Executive Salary Continuation Plan, as amended and restated effective June 28, 2022, incorporated by reference to Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2022.
10.6	*	Elevance Health Directed Executive Compensation Plan, as amended and restated effective June 28, 2022, incorporated by reference to Exhibit 10.6 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2022.
10.7	*	Elevance Health Board of Directors Compensation Program, as amended and restated effective May 10, 2023, incorporated by reference to Exhibit 10.7 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2023.
10.8	*	Elevance Health Board of Directors' Deferred Compensation Plan, as amended and restated effective June 28, 2022, incorporated by reference to Exhibit 10.8 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2022.
10.9	* (a)	Form of Employment Agreement between the Company and each of the following: John E. Gallina and Peter D. Haytaian, incorporated by reference to Exhibit A to Exhibit 10.41 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2007.
	(b)	Form of Employment Agreement between the Company and Gail Boudreaux, incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on November 6, 2017.
	(c)	Form of Employment Agreement between the Company and each of the following: Charles Morgan Kendrick and Felicia F. Norwood incorporated by reference to Exhibit 10.9(d) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018.
	(d)	Form of Employment Agreement between the Company and each of the following: Mark Kaye and Ratnakar Lavu, incorporated by reference to Exhibit 10.9(d) to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2023.
10.10	*	Offer Letter, by and between the Company and Gail Boudreaux, dated as of November 5, 2017, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on November 6, 2017.
10.11	*	Offer Letter, by and between the Company and Mark Kaye, dated as of August 2, 2023, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on August 8, 2023.
10.12		Blue Cross License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through September 19, 2024.
10.13		Blue Shield License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through September 19, 2024.
19.1		Elevance Health, Inc. Insider Trading Policy, last amended January 31, 2025.
21		Subsidiaries of the Company.
23		Consent of Independent Registered Public Accounting Firm.
31.1		Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2		Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1		Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2		Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
97.1		Elevance Health, Inc. Incentive Compensation Recoupment Policy, amended and restated effective as of October 3, 2023, incorporated by reference to Exhibit 97 to the Company's Annual Report on Form 10-K for the year ended December 31, 2023.

Exhibit Number	Exhibit
101.INS	XBRL Instant Document - the instant document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document.
104	Cover Page Interactive Data File formatted in Inline XBRL and contained in Exhibit 101.
*	Indicates management contracts or compensatory plans or arrangements.

(b) Exhibits

The response to this portion of Item 15 is set forth in paragraph (a) 3 above.

(c) Financial Statement Schedule

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

ITEM 16. FORM 10-K SUMMARY.

None.

Schedule II—Condensed Financial Information of Registrant

Elevance Health, Inc. (Parent Company Only)
Balance Sheets

(In millions, except share data)	December 31, 2024	December 31, 2023
Assets		
Current assets:		
Cash and cash equivalents	$ 1,870	$ 1,483
Equity securities	487	80
Other receivables	49	58
Net due from subsidiaries	4,697	—
Other current assets	705	959
Total current assets	7,808	2,580
Other invested assets	3,636	822
Property and equipment, net	159	178
Deferred tax assets, net	—	199
Investments in subsidiaries	63,173	63,426
Other noncurrent assets	584	217
Total assets	$ 75,360	$ 67,422
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	$ 737	$ 1,709
Net due to subsidiaries	—	734
Current portion of long-term debt	1,649	1,649
Other current liabilities	610	413
Total current liabilities	2,996	4,505
Long-term debt, less current portion	29,193	23,221
Deferred tax liabilities, net	55	—
Other noncurrent liabilities	1,801	390
Total liabilities	34,045	28,116
Commitments and contingencies—Note 5		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value $0.01, shares authorized - 900,000,000; shares issued and outstanding - 227,479,695 and 233,071,088	2	2
Additional paid-in capital	8,911	8,868
Retained earnings	33,549	31,749
Accumulated other comprehensive loss	(1,147)	(1,313)
Total shareholders' equity	41,315	39,306
Total liabilities and shareholders' equity	$ 75,360	$ 67,422

See accompanying notes.

Elevance Health, Inc. (Parent Company Only)
Statements of Income

(In millions)	Years ended December 31 2024	2023	2022
Revenues			
Net investment income	$ 110	$ 25	$ 4
Net (losses) gains on financial instruments	(23)	(100)	2
Service fees	9	8	7
Total revenues (losses)	96	(67)	13
Expenses			
Operating expense	279	352	188
Interest expense	1,172	1,017	845
Total expenses	1,451	1,369	1,033
Loss before income tax credits and equity in net income of subsidiaries	(1,355)	(1,436)	(1,020)
Income tax credits	(477)	(214)	(461)
Equity in net income of subsidiaries	6,858	7,209	6,453
Shareholders' net income	$ 5,980	$ 5,987	$ 5,894

See accompanying notes.

Elevance Health, Inc. (Parent Company Only)
Statements of Comprehensive Income

(in millions)	Years ended December 31		
	2024	**2023**	**2022**
Shareholders' net income	$ 5,980	$ 5,987	$ 5,894
Other comprehensive income (loss), net of tax:			
Change in net unrealized gains/losses on investments	109	1,123	(2,249)
Change in non-credit component of impairment losses on investments	1	—	(3)
Change in net unrealized gains/losses on cash flow hedges	4	18	10
Change in net periodic pension and other benefit costs	60	40	(70)
Change in future policy benefits	(2)	(3)	32
Foreign currency translation adjustments	(6)	(1)	(13)
Other comprehensive income (loss)	166	1,177	(2,293)
Total shareholders' comprehensive income	$ 6,146	$ 7,164	$ 3,601

See accompanying notes.

Elevance Health, Inc. (Parent Company Only)
Statements of Cash Flows

(In millions)	Years ended December 31 2024	2023	2022
Net cash provided by operating activities	$ 1,451	$ 4,113	$ 1,447
Investing activities			
Purchases of investments	(3,240)	(95)	(367)
Proceeds from sales, maturities, calls and redemptions of investments	1,567	212	618
Repayment of note to subsidiary	—	—	1,500
Capitalization of subsidiaries	(324)	(363)	(411)
Changes in securities lending collateral	(16)	42	36
Purchases of property and equipment, net of sales	(36)	(55)	(47)
Net cash (used in) provided by investing activities	(2,049)	(259)	1,329
Financing activities			
Net repayments of short-term borrowings	—	—	(300)
Proceeds from long-term borrowings	7,710	2,574	3,071
Repayments of long-term borrowings	(1,650)	(1,909)	(1,899)
Changes in securities lending payable	16	(42)	(36)
Repurchase and retirement of common stock	(2,900)	(2,676)	(2,316)
Cash dividends	(1,586)	(1,466)	(1,290)
Proceeds from issuance of common stock under employee stock plans	221	152	182
Taxes paid through withholding of common stock under employee stock plans	(109)	(99)	(93)
Other, net	(717)	153	217
Net cash provided by (used in) financing activities	985	(3,313)	(2,464)
Change in cash and cash equivalents	387	541	312
Cash and cash equivalents at beginning of year	1,483	942	630
Cash and cash equivalents at end of year	$ 1,870	$ 1,483	$ 942

See accompanying notes.

Elevance Health, Inc.
(Parent Company Only)
Notes to Condensed Financial Statements

December 31, 2024
(In Millions, Except Per Share Data)

1. Basis of Presentation and Significant Accounting Policies

In the parent company only financial statements of Elevance Health, Inc. ("Elevance Health"), Elevance Health's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. Elevance Health's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Elevance Health.

Elevance Health's parent company only financial statements should be read in conjunction with Elevance Health's audited consolidated financial statements and the accompanying notes included in Part II, Item 8 of this Annual Report on Form 10-K.

2. Subsidiary Transactions

Dividends from Subsidiaries

Elevance Health received cash dividends from subsidiaries of $6,322, $4,909 and $3,097 during 2024, 2023 and 2022, respectively.

Dividends to Subsidiaries

Certain subsidiaries of Elevance Health own shares of Elevance Health common stock. Elevance Health paid cash dividends to subsidiaries related to these shares of common stock in the amount of $78, $71 and $61 during 2024, 2023 and 2022, respectively.

Investments in Subsidiaries

Capital contributions to subsidiaries were $324, $363 and $411 during 2024, 2023 and 2022, respectively.

Amounts Due From and To Subsidiaries

At December 31, 2024 and 2023, Elevance Health reported amounts due from and (to) subsidiaries of $4,697 and $(734), respectively. The amounts due from and (to) subsidiaries primarily include amounts for allocated operating expenses or daily cash management activities. These items are routinely settled, and as such, are classified as current liabilities or assets.

In June 2021 Elevance Health entered into a short-term loan agreement with a subsidiary for the amount of $1,500. This loan was repaid in February 2022.

Guarantees on Behalf of Subsidiaries

Elevance Health guarantees contractual or financial obligations or solvency requirements for certain of its subsidiaries. These guarantees approximated $912 at December 31, 2024. There were no payments made on these guarantees in 2024.

3. Derivative Financial Instruments

The information regarding derivative financial instruments contained in Note 6, "Derivative Financial Instruments," of the Notes to Consolidated Financial Statements of Elevance Health and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

4. Long-Term Debt

The information regarding long-term debt contained in Note 13, “Debt,” of the Notes to Consolidated Financial Statements of Elevance Health and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

5. Commitments and Contingencies

The information regarding commitments and contingencies contained in Note 14, “Commitments and Contingencies,” of the Notes to Consolidated Financial Statements of Elevance Health and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

6. Capital Stock

The information regarding capital stock contained in Note 15, “Capital Stock,” of the Notes to Consolidated Financial Statements of Elevance Health and its subsidiaries, included in Part II, Item 8 of this Annual Report on Form 10-K, is incorporated herein by reference.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

ELEVANCE HEALTH, INC.

By: /s/ GAIL K. BOUDREAUX
Gail K. Boudreaux
President and Chief Executive Officer

Dated: February 20, 2025

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ GAIL K. BOUDREAUX **Gail K. Boudreaux**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 20, 2025
/s/ MARK B. KAYE **Mark B. Kaye**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 20, 2025
/s/ RONALD W. PENCZEK **Ronald W. Penczek**	Chief Accounting Officer and Controller (Principal Accounting Officer)	February 20, 2025
/s/ ELIZABETH E. TALLETT **Elizabeth E. Tallett**	Chair of the Board	February 20, 2025
/s/ R. KERRY CLARK **R. Kerry Clark**	Director	February 20, 2025
/s/ SUSAN D. DEVORE **Susan D. DeVore**	Director	February 20, 2025
/s/ ROBERT L. DIXON, JR. **Robert L. Dixon, Jr.**	Director	February 20, 2025
/s/ LEWIS HAY III **Lewis Hay III**	Director	February 20, 2025
/s/ BAHIJA JALLAL **Bahija Jallal**	Director	February 20, 2025
/s/ ANTONIO F. NERI **Antonio F. Neri**	Director	February 20, 2025
/s/ RAMIRO G. PERU **Ramiro G. Peru**	Director	February 20, 2025
/s/ RYAN M. SCHNEIDER **Ryan M. Schneider**	Director	February 20, 2025
/s/ DEANNA D. STRABLE **Deanna D. Strable**	Director	February 20, 2025

EXHIBIT 10.12

BLUE CROSS LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their September 19, 2024, meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Cross Plan, known as _____(the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans (unless otherwise defined in this Agreement, Plans shall mean Member Plans as that term is defined in BCBSA's Bylaws) ("Member Plans"), facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA in 1972 simultaneously executed the BCA License Agreement (s) and the Ownership Agreement; and

WHEREAS, BCBSA and the Plan desire to supersede said Agreement(s) and to revise certain provisions of the Ownership Agreement to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE CROSS system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement (“Agreement” or “Primary License Agreement”), the right to use BLUE CROSS in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Workers’ Compensation Insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms “Health Coverage,” “Eligibility” and “Enrollment” are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the Agreement attached as Exhibit 1A1 hereto (the “Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products”) and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers’ Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the “Controlled Affiliate License”); and iv) regional Medicare Advantage PPO products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the “Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products”); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the “Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products”). A “Controlled Affiliate” is defined as an entity that meets the requirements of bona fide control stated herein and has executed a Controlled Affiliate License Agreement. Unless otherwise approved in writing by BCBSA, bona fide control shall have the meaning set forth in Paragraphs 2a and 2b. If the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons with authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA.

Amended as of June 15, 2023

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that the Plan (the “Sponsoring Plan”) must have:

A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

B. The legal authority directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in through (c) hereof, the Controlled Affiliate’s establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

1. Change its legal and/or trade name;

2. Change the geographic area in which it operates;

3. Change any of the types of businesses in which it engages;

4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

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

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

C. With respect to a Controlled Affiliate that is 100% controlled by Member Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the legal authority by the Sponsoring Plan together with such other Member Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Member Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Member Plans each having an ownership interest. Such 100% control and ownership by Member Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Member Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-1 to Exhibit 1 attached hereto; or

D. With respect to a Controlled Affiliate that is 100% controlled by another Member Plan which on a Blue-branded basis within the Plan's Service Area, offers solely a Basic Medicare Part D Prescription Drug product, the legal authority by the other Member Plan: (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Member Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by the Member Plan shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and Participating Plan as defined on the Controlled Affiliate License Agreement shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-2 to Exhibit 1 attached hereto.

E. With respect to a Controlled Affiliate that operates as a clinic, the legal authority by the Sponsoring Plan to exercise control over the policy and operations of the Controlled Affiliate as defined in Exhibit 1, Standard 1(E) and the Guidelines to Administer Standard 1(E). In addition, if the clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur.

F. With respect to any Plan affiliation(s) entered into after June 15, 2023, the Plan has entered into a contractual agreement that meets the criteria set forth in Exhibit 1, Standard 1(F) and the Guidelines to Administer Standard 1(F) and Protocol for Determining Automatic Transfer of Primary License Agreement Pursuant to Contractual Control.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the "Controlling Plans"); and

B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

1. Change its legal and/or trade names;

2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Amended as of June 19, 2014

(The next page is page 3)

3. With respect to an affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the affiliate and permit such affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified in the BlueCross BlueShield Brand Book consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any unlicensed affiliate to use the Licensed Marks or Name.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Cross Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency;or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

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

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan (“Excess Institutional Voter”), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan (“Excess Noninstitutional Voter”) unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan’s then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below (“Excess Owner”), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination

becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)- (d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an “Institutional Investor” if (but only if) such Person (i) is an entity or group identified in the SEC’s Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person’s Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) “Noninstitutional Investor” means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

(The next page is page 6)

10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; or (c) until termination of aforesaid Ownership Agreement; or (d) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three- fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities And costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

15.(a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association’s Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of March 26, 2015

(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans as provided in the Ownership Agreement.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re- Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re- Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of the base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only to the extent that, in

BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

(iv) The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential

new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account- data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

(v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.

(vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements this paragraph 15(d).

(vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

(ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA's Bylaws.

Amended as of June 15, 2023

(The next page is page 9)

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By_____

Title_____

Date_____

PLAN:

By_____

Title_____

Date_____

EXHIBIT 1

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
(**Includes revisions adopted by Member Plans through their November 16, 2023 meeting**)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____(“Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan, known as _____ ("Plan" or “Sponsoring Plan”), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers’ compensation insurance, and (ii) underwriting the indemnity portion of workers’ compensation insurance, provided that Controlled Affiliate’s total premium revenue comprises less than 15 percent of the Sponsoring Plan’s net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan Subject to paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of ControlledAffiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate’s governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate’s establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(2) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the Sponsoring Plan has the legal authority together with such other Plans:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute a separate Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-1 for each product noted in Paragraph 2E(3) that is licensed to use the Marks.

Or

(4) With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis, only offers a Basic Medicare Part D Prescription Drug Plan product, the Sponsoring Plan has the legal authority:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Participating Plan as defined in Exhibit B-2 and the Sponsoring Plan shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-2.

Or

(5) With respect to a Controlled Affiliate that operates as a clinic, absent an alternative method of control approved in writing by BCBSA, the Sponsoring Plan shall have bona fide operational control over the Controlled Affiliate as specified in Exhibit A, Standard 1(E) and the Guidelines to Administer Standard 1(E). In addition, if the clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur.

Or

(6) With respect to any Plan affiliation(s) entered into after June 15, 2023, the Controlled Affiliate has entered into a contractual agreement with the Sponsoring Plan that meets the criteria set forth in Exhibit A, Standard 1(F) and the Guidelines to Administer Standard 1(F) and Protocol for Determining Automatic Transfer of Primary License Agreement Pursuant to Contractual Control.

3. FOR-PROFIT, PUBLICLY TRADED LICENSEES

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

(1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.

(2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.

(3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(4) The Controlled Affiliate's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstitutional Investor, other than a Plan or Plans or Controlled Affiliate Licensee or Licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a

Plan or Plans or Controlled Affiliate Licensee or Licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than amerger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4) (a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b), or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(6) For purposes of paragraph 3A(4) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(3) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be

limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for

specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvencyor debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to

constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any Controlled Affiliates directly or indirectly owned by the terminated for-profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 8(B) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated.

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re- Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

The Re-Establishment Fee shall be indexed to a base fee of $80. The Re- Establishment Fee through December 31, 2005 shall be $80. The Re- establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re- Establishment Fee shall be fixed at the then- current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re- Establishment Fee have been finally resolved; and provided further that the award shall be

based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any costs associated with reestablishing the Service Area, including payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term ‘Plans’ shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA’s Bylaws.

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Plan:

By:_____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

Amended as of March 26, 2015

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS
November 2023

PREAMBLE

For purposes of definition:

- A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.

- A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

Amended as of September 19, 2014

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA “Health Risk-Based Capital (HRBC)” as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers’ compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation, The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

EXHIBIT A (continued)

Matrix to Determine which Standards for Licensed Controlled Affiliates Apply

Each licensed Controlled Affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed Controlled Affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan ⇩ Standard 1A Or Contractual Control ⇩ Standard 1F	50% by Sponsoring Plan ⇩ Standard 1B	100% Plan Control but less than 50% Sponsoring Plan Control and it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services ⇩ Standard 1C	100% Sponsoring Plan control and on a Blue- branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product ⇩ Standard 1D	At least 50% by Sponsoring Plan or operational Control by Sponsoring Plan and it solely operates as a Clinic as defined in Standard 1E ⇩ Standard 1E

IN ADDITION,

2. Is risk being assumed?

⇙	Yes ⇩	⇘	⇙	No ⇩
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance ⇩ Standards 6A- 6E, 9	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ⇩ Standard 2 (Guidelines 1.1,1.2) and Standard 9	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ⇩ Standard 5E	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ⇩ Standard 2 (Guidelines 1.1,1.3) and Standard 9	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ⇩ Standard 5E

IN ADDITION,

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

Yes	No
⇩ Standard 3A	⇩ Standard 3B

Matrix to Determine which Standards for Licensed Controlled Affiliates Apply

Each licensed Controlled Affiliate shall be subject to certain standards as determined below:

IN ADDITION,

4. Is the licensed Controlled Affiliate operating as a Clinic as defined in Standard 1(E)?

Yes
⇩ Standard 3C and Standard 2, 1.4 (if organized as a health plan that also operates as a Clinic)

1. If the Controlled Affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?

Yes	No		
⇩	⇙	⇙	⇘
Standards 5A-5F	Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C) ⇩ Standards 4,7,8B,9	Controlled Affiliate is a former primary licensee ⇩ Standards 4,7,8A,9	Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) ⇩ Standards 4,7,8B,9

Amended September 19, 2024

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA , has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority, directly or indirectly through wholly-owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business

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- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

1C.) The Standard for a Controlled Affiliate that offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and service and has 100% Plan control but less than 50% Sponsoring Plan Control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority together with Other Plans:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for- profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

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EXHIBIT A (continued)

1D.) The Standard for a Controlled Affiliate that on a Blue-branded basis only offers a Basic Medicare Part D Prescription Drug Plan product and has 100% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) on a Blue-branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product; and (ii) the Sponsoring Plan has the legal authority:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA.

Further, the Sponsoring Plan and Participating Plan shall execute the Addendum to Controlled Affiliate License.

1E.) The Standard for a Controlled Affiliate that operates as a Clinic and the Sponsoring Plan has control of the Clinic is:

A Controlled Affiliate shall be organized in such a manner that it operates as a Clinic and the Sponsoring Plan exercises operation control over the Controlled Affiliate.

In addition, if the Clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate.

1F.) The Standard for possessing contractual control over a Controlled Affiliate is:

With respect to any Plan affiliations entered into after June 15, 2023, a Primary Licensee has entered into a contractual agreement where:

(i) It has outsourced 50% or more of the expenditures for overall management and strategic direction to another Primary Licensee, or

(ii) A regulatory agency has determined that a change of control or a corporate affiliation has occurred, or

(iii) Officers of a Primary Licensee perform roles for another Primary Licensee.

(This excludes Controlled Affiliates pursuant to paragraphs 2(a)(C) and 2(a)(D) of the Primary License Agreement).

The Primary License Agreement will automatically transfer, and the Plan will automatically become a Controlled Affiliate of the other Primary Licensee unless otherwise approved in writing by BCBSA.

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EXHIBIT A (continued)

Standard 2 – Financial Responsibility
Standard is:
A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Shield Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, the Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specifically exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 – State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:
A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:
A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

3C.) The Standard for a Controlled Affiliate that operates as a Clinic as defined in Standard 1(E) is:
A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

Standard 4 – Reports and Records for Certain Smaller Controlled Affiliates
For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:
A Controlled Affiliate and/or its Sponsoring Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Amended as of September 19, 2024

EXHIBIT A (continued)

Standard 5 – Other Standards for Larger Controlled Affiliates
Standards 5(A) – (F) that follow apply to larger Controlled Affiliates.

Standard 5(A): Board of Directors The Standard is:
A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members1. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 5(B): Responsiveness to Customers The Standard is:
A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 5(C): Participation in National Programs The Standard is:
A Controlled Affiliate shall effectively and efficiently participate in Inter-Plan Programs, including, but not limited to the BlueCard Program and Inter-Plan Medicare Advantage Program, for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.
Controlled Affiliates must also participate in Business Associate Agreement for Blue Cross and Blue Shield Licensees .

Standard 5(D): Local Best Efforts The Standard is:
Notwithstanding any other provision in the Plan’s License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross [applicable to Blue Cross Licensees] and Blue Shield [applicable to Blue Shield Licensees] Marks.

Standard 5(E): Financial Responsibility The Standard is
A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers and shall take such action as required to ensure its financial performance in programs and contracts of an inter- licensee nature or where BCBSA is a party (formerly Standard 6(D)). A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose (formerly Standard 6(F)).

1 A "public member" excludes any person who:
1. is engaged or has engaged at any time in the practice of a health care profession (other than an employee of the Plan);
2. is a director, officer, partner or employee of an organization that primarily sells health care services (other than the Plan or an organization controlled by the Plan); or
3. is a director, officer, partner or employee of an organization of health care providers; or
4. has direct or indirect beneficial interest of more than five percent of the equity of an organization that sells or delivers health care services.

EXHIBIT A (continued)

Standard 5(F): Control by Unlicensed Entities Prohibited The Standard is:
No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 6 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates
Standards 6(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 6(A): Financial Responsibility The Standard is:
A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 6(B): Reports and Records The Standard is:
A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Triennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers, and; and

D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports;* and

F. Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter**, articles of incorporation***, or bylaws**, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care. *

Standard 6(C): Loss Prevention The Standard is:
A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

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* Submit within 30 days of change to: Associate General Counsel, Licensure, Blue Cross and Blue Shield Association, 200 East Randolph Street, Suite 1800, Chicago, IL 60601

** Include a red-lined version that clearly identifies the changes

Standard 6(D): Claims Administration The Standard is:
A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 6(E): Disability and Provider Management The Standard is:
A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Standard 7 – **Cooperation with Controlled Affiliate License Performance Response Process Protocol**
The Standard is:
A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Organization and Governance Committee in the Administration of the Controlled Affiliate Licensee Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 8 – **Participation in National Programs by Smaller Controlled Affiliates** Standard 8(A): Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees
The Standard is:
A smaller Controlled Affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in Inter-Plan Programs, including, but not limited to the BlueCard Program and Inter-Plan Medicare Advantage Program, for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. Financial Requirements include:
   - Standard 5(E): Financial Responsibility; or
   - A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

B. Reporting requirements include:
   - Semi-annual Health Risk-Based Capital (HRBC) Report as defined by the NAIC.

Standard 8(B): Participation in National Programs by Smaller Controlled Affiliates The Standard is:
A smaller Controlled Affiliate shall effectively and efficiently participate in Inter-Plan Programs, including, but not limited to the BlueCard Program and Inter-Plan Medicare Advantage Program, for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. Financial Requirements include:
1. Standard 5(E): Financial Responsibility; or
2. A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Standard 9: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees
The Standard is:
Effective April 14, 2003, all smaller Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B-1

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____("Controlled Affiliate Licensee") and _____("Sponsoring Plan") dated the_____day of_____("Agreement"). The parties to this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ('Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans market in its Service Area more efficiently and with less risk through an enterprise jointly owned and controlled with other Plans than through a wholly owned and Controlled Affiliate Licensee.

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. This Addendum is limited to [identify product name].

2. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans services being offered under the Agreement and being involved in network development and provider engagement functions.

3. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it

will not take any action, either individually or jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

4. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 8 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Other Plan 1]

By: _____

[Other Plan 2]

By: _____

EXHIBIT B-2

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1D.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____("Controlled Affiliate Licensee"), _____("Sponsoring Plan") and _____ ("Participating Plan") dated the _____ day of _____ ("Agreement").

WHEREAS, the Participating Plan is defined as the Plan that holds the Primary License with BCBSA to use the Service Marks in the Service Area where the Controlled Affiliate will use the Service Marks;

WHEREAS, the Participating Plan asserts that it can offer a lower cost Basic Medicare Part D Prescription Drug Plan product more efficiently in the Participating Plan's Service Area through the Controlled Affiliate Licensee;

WHEREAS, the Controlled Affiliate shall only use the Service Marks inside of the Participating Plan(s) Service Area subject to each Participating Plan signing a separate Addendum;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1D permits the licensing of a Controlled Affiliate that is 100% owned and controlled by a Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan, Controlled Affiliate and the Participating Plan enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Participating Plan shall participate in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that the Participating Plan shall conduct sales support and marketing of the Controlled Affiliate's Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area. Any other form of participation shall require BCBSA's written approval.

2. Participating Plan agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with the Sponsoring Plan or Controlled Affiliate Licensee, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. The Controlled Affiliate Licensee shall only use the Licensed Marks authorized by the Participating Plan in connection with the Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area.

4. The Sponsoring Plan and Controlled Affiliate acknowledge that it has reviewed the Agreement and understands that Participating Plan has the right to terminate this Agreement: (i) immediately upon the expiration or termination of the Plan Participation Agreement by and between Participating Plan and Controlled Affiliate upon written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, or (ii) without cause upon 18 months written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, and that such right is unfettered and may be exercised by Participating Plan in its sole discretion. In the event that Participating Plan and Controlled Affiliate fail to execute the Plan Participation Agreement by__(Date), Participating Plan may terminate this Agreement immediately upon notice to Sponsoring Plan, Controlled Affiliate Licensee and Licensor.

5. This Agreement and all of Controlled Affiliate Licensee's rights hereunder shall immediately terminate without any further action by any party or entity in the event that the Sponsoring Plan or Participating Plan ceases to be authorized to use the Licensed Marks and Name.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein. BLUE CROSS BLUE SHIELD

ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Participating Plan]

By: _____

Amended March 17, 2016

EXHIBIT C

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED
AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September 19, 2014

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

EXHIBIT 1A

CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO LIFE INSURANCE COMPANIES

(Includes revisions adopted by Member Plans through their November 16, 2023 meeting)

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA") _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as_____("Plan").

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Cross Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Cross Controlled Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of ControlledAffiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

An annual fee of five thousand dollars ($5,000) per license, plus

.05% of gross revenue per year from branded group products, plus

.5% of gross revenue per year from branded individual products plus

.14% of gross revenue per year from branded individual annuity products.

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBA's Bylaws.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of June 15, 2023

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

Amended as of June 16, 2005

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

Controlled Affiliate:

By:_____

Date:_____

Plan:

By:_____

Date:_____

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to- time upon the affirmative vote of three- fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement. The LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA’s Board of Directors and its Organization and Governance Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

Exhibit 1A1

CONTROLLED AFFILIATE TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILTY INSURANCE PRODUCTS

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, (“Life and Disability Controlled Affiliate”) which is a company offering life and disability insurance products owned and controlled by _____, _____, _____(individually, “Sponsoring Plan” and when referred to collectively, “Sponsoring Plans”).

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof (“Licensed Marks”);

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans’ Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, (“Blue Plans”) consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2)Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3) Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing (“Licensed Products”) in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to “Consenting Plan(s)”) must clearly identify the Consenting Plan (for example, a statement on such materials that reads “This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]”);

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan’s existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license

(5) agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(6) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly- owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance

thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or

(2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or

(3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars ($5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term ‘Plans’ shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA’s Bylaws.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

Life and Disability Controlled Affiliate:

By:_____

Date:_____

Sponsoring Plan:

By:_____

Date:_____

Name:_____

Sponsoring Plan:

By:_____

Date:_____

Name: _____

[Add other Sponsoring Plans as necessary]

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products (“licensee”) shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then- current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Organization and Governance Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B

CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and_____("Life and Disability Controlled Affiliate"), and the Blue Cross and Blue Shield Association ("BCBSA") and shall be deemed effective on_____("Effective Date").

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the "Brands");

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area ("Service Area");

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products ("Products") as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products ("Life and Disability License Agreement");

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan's Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate's use of the Brands in Blue Plan's Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan's Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan's license agreement(s) with BCBSA. Life and Disability Controlled Affiliate's rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.

2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales, marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

_____

5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;

6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.

9. This Consent Agreement may be terminated as follows:

   A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;

   B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or

   C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.

10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by:

[Blue Plan]:

By:_____

Title:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By:_____

Title:_____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By:_____

Title:_____

Exhibit 1B

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their November 16, 2023 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____(the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the
Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4)failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and

any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three- fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last

known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term ‘Plans’ shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA Bylaws.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS

November 2023

PREAMBLE
The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly- owned subsidiaries:

   (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

   (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

   (c) exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

a. Inter-Plan Teleprocessing System (ITS); and

b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENTS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

Exhibit 1C

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS
(Adopted by Member Plans at their November 16, 2023 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____(“Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____(“Controlling Plans”), each of which is also a Party hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services (“CMS”) to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter “regional PDP products).”

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states:

_____(the “Region”). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time- to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

A. Controlled Affiliate is owned or controlled by two or more Controlling Plans;

B. Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the
Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing Body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

i. change its legal and/or trade names;

ii. change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to

complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim

trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license

termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, shall occur pursuant to BCBSA's Bylaws.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS
November 2023

PREAMBLE
The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time- to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly- owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and
b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENTS APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

EXHIBIT 2
Membership Standards

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a “Shell Holding Company” is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a “Hybrid Holding Company” is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1: A Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 2: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers and shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party (formerly Standard 6.) Annually a Plan, excluding a Shell Holding Company, shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose (formerly Standard 9).

Standard 3: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 4: A Plan shall effectively and efficiently participate in Inter-Plan Programs, including, but not limited to the BlueCard Program and Inter-Plan Medicare Advantage Program, for the purposes of providing portability of membership between Plans and ease of claims processing for customers receiving benefits outside of Control/Home Plan's Service Area.

Standard 5: Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Cross [for Blue Cross Licensees] and Blue Shield [for Blue Shield Licensees] Marks.

Standard 6: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services if such control or acquisition has the potential to impair (1) the value of the Blue Marks or (2) the competitiveness or efficiency of Blue Branded business or the Blue Marks.

Standard 7: No provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.

Standard 8: Each Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

EXHIBIT 3

GUIDELINES WITH RESPECT TO USE OF
LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS

1. The strength of the Blue Cross/Blue Cross National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends. The policies and provisions governing National Accounts, including but not limited to the Inter- Plan Programs Policies and Provisions, are incorporated by reference into these guidelines. If there is a conflict between these guidelines and the policies and provisions governing National Accounts, the policies and provisions control the resolution of such conflict.

2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision- making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. Unless otherwise provided in the policies and provisions governing an applicable National Account, the Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.

3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.

4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 24, 2024

EXHIBIT 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by MSC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of applicable Inter-Plan Programs.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

1. A Plan and its licensed Controlled Affiliate(s) “Licensees” may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. Licensees may NOT use the Brands in communications or transactions with beneficiaries or providers in a Government program located outside its Service Area. For purposes of this Paragraph 1, the term “Government Programs” shall mean any non-risk Medicare, Medicaid, and other non-risk program administered by a government authority, and any successor program. Contracts with the United States Government or the Government of a State or Municipality to provide health care coverage to its employees are not considered Government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, Licensees, except for Regional MA PPO and PD Controlled Affiliates (see paragraph 3 below), may use the Licensed Marks and Name (also referred to as “Brands”) outside the Licensee’s Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

   a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

   b. distributing business cards other than in marketing and selling;

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

2.2 Marketing Spillover

a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Licensee, provided that no Licensee may advertise outside its Service Area on the national broadcast or cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Licensee's Service Area;

2.3 Provider Contracting

a. contracting with health care providers or soliciting such contracts in a Contiguous Area in order to serve its subscribers residing or working in its service area;

b. issuing a small sign containing the legal name or trade name of the Licensee for display by a provider in a Contiguous Area to identify the provider as a participating provider of the Licensee;

c. negotiating case-specific reimbursement rates with a provider that does not have a contract applicable to a specific member's services rendered or to be rendered with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located, so long as

(1) the Licensee engaging in the negotiations complies with all applicable Inter- Plan Programs Policies and Provisions and Brand Regulations related to case- specific rate negotiations, and

(2) the Licensee (or all Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located provides consent before negotiations commence.

d. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Licensee's members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network.

e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Licensee's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;

f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Licensee's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

(i) For purposes of this Exhibit, "routine dental benefit" covers four classes of dental services: (1) preventative services (e.g., teeth cleaning, oral exams, x-ray and lab exams); (2) restorative services (e.g. fillings, crowns, inlays/onlays, root canal, periodontal treatments, extractions, repairs to partials); (3) construction of dentures and bridges; and (4) orthodontic tooth guidance appliances (e.g., braces, habit-breaking appliances).

(ii) Examples of services that are not within the scope of "routine dental" include any medical oral or maxillofacial procedures, including maxillofacial surgery, and diagnosis or treatment of the oral or maxillofacial region as a result of disease, chronic illness, or injury.

g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Licensee's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

(i) For purposes of this Exhibit, "routine vision benefit" covers routine eye exams, glasses (frames and lenses), contact lenses, and Lasik surgery.

(ii) Examples of services that are not within the scope of "routine vision" include any medical vision procedures, including eye surgery, and the diagnosis or treatment of the eye as a result of disease, chronic illness, or injury.

h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Licensee's Service Area;

i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Licensee's Service Area;

j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Licensee's Service Area;

k. contracting with a company that operates provider sites in the Licensee's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Licensee's Service Area;

l. contracting with a company that makes health care professionals available in the Licensee's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Licensee's Service Area.

m. Permitting Control/Home Plans' ability to resolve members' service issues requiring outreach to out-of-area providers as set forth in the Inter-Plan Programs and Inter- Plan Medicare Advantage Program Policies.

n. contracting with national telemedicine and virtual healthcare (i.e., telehealth providers) companies nationally for all virtual-only health care services in accordance with Inter-Plan Programs and Inter-Plan Medicare Advantage Policies and Provisions.

2.4 Services to National Accounts

a. when applicable Inter-Plan Programs Policies and Provisions ("IP Policies") specifically permit a Plan to contract with a National Account headquartered outside of a Plan's Service Area to offer Blue-branded Health Coverage to the National Account. Nothing in this rule 2.4 supersedes the IP Policies.

b. in conjunction with contracting with a National Account as offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:

(i) the Licensee has no contact or interaction with providers outside of the Licensee's Service Area, except as specifically provided in the IP Policies and in 2.4(c); and

(ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Licensed Marks and Name a local plant, office or division of the account that is outside of the Control/Alternate Licensee's Service Area, the Control/Alternate Licensee may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and

(iii) if the Licensee provides an information card to the non-Blue Health Coverage members, the card may not display the Licensed Marks in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

2.4 Services to National Accounts (continued)

For purposes of this subparagraph b, and below subparagraph c, the following definitions apply:

"Health and Wellness Program" shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

"Health Coverage" shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

c. as part of a Health and Wellness Program that is otherwise compliant with subparagraph b above, contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event ("Event") held at a National Account's worksite outside of the Licensee's Service Area, provided that:

   (i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and

   (ii) neither such services nor their costs are applied as claims against any benefit plan; and

   (iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite.

d. in conjunction with contracting with a National Account to offer Blue branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan and/or licensed Controlled Affiliate, provided that:

   (i) in performing such functions, Licensee does not use the Licensed Marks and Name in any communications with health care providers outside of the Licensee's Service Area, and otherwise limits its use of the Licensed Marks and Name outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and

   (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Licensed Marks and Name a local plant, office or division of the account that is outside of the Plan's Service Area, Licensee may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

e. in conjunction with contracting with a National Account to perform or investigate fraud, waste and abuse investigation activities for a non-participating provider in a Par/Host Plan's service area, as long as the Control/Home Plan is given permission to do so by the Par/Host Plan and specific conditions are met in accordance with Inter-Plan Programs and Inter-Plan Medicare Advantage Program policies.

For purposes of this Exhibit, the following definitions apply:

"Eligibility" means services that manage the account's eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of "hour-banking" for union environments in which union members can bank hours to remain eligible for benefits.

"Enrollment" means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account's benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account's benefit plan providers;
- review and reconciliation of error reports received from the account's benefit plan providers; and
- transmission of information to the account's payroll system (e.g., benefit deductions, employee demographic data).

2.5 Conferences and Symposiums

a. submitting scholarly articles authored or co-authored by the Licensee or its respective employees for publication in peer-reviewed journals (see BCBSA's Brand Use Center);

b. permitting an internal representative of the Licensee to participate at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee and/or the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee and/or the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website. A participating Licensee will also be permitted to display/share communications at the conference or symposium subject to the requirements set forth in (c) below.

c. Participating in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services unless there is a clear connection between the Licensee and the reasoning for attending such conference or symposium (e.g., healthcare decision makers within the Licensee's service area will also be at the conference, the conference has a nexus to the Licensee's service area even though the conference is taking place elsewhere) and the Licensee has provided BCBSA with advanced written notice prior to participating.

    (i) Licensees may establish a booth to support at Conferences or Symposiums consistent with the above. Any materials containing the Brands must include a disclosure clearly indicating the Licensee's name or trade name as well as an indication of where the Licensee provides products and services (i.e. BCBS of Geography).

    (ii) Licensees may not co-exhibit or promote the products and/or services of an unlicensed affiliate.

2.6 Other Uses*

a. entering into a license agreement between and among BCBSA, the Licensee and a debit card issuer located outside the Licensee's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;

b. appearing in communications issued by an independent third party to recognize outstanding performance of the Licensee or a member of the Licensee's senior management as part of an established program of the third party for which the Licensee has provided information to be considered for the recognition The areas of recognition must relate to a Licensee's performance as an employer or corporate citizen, or for a corporate business function other than sales or marketing (e.g. human resources, underwriting). The third party's communication of the recognition must appear only in its customary media and form used with the established program.

c. to identify itself as being a joint sponsor of an event, program or activity (e.g., a 5k run, a public event, a wellness education seminar) along with other Licensees provided that the following conditions are met:

(i) Written notification is provided to BCBSA staff at least 30 days before the event or when the Licensee executes a sponsorship agreement, whichever is earlier, identifying the joint sponsorship opportunity and the participating licensees, and including a sample of the proposed branding consistent with the template that is required under 2.6(c)(v).

(ii) Communications and materials relating to such joint sponsorship may appear solely within the Service Areas of Licensees who have provided prior consent, are participating in such joint sponsorship program and whose names appear in such communications and materials. In each participating Licensee's Service Area, such participating Licensee's name must appear in all such communications and materials with at least equal prominence as the names of other listed participating Licensees;

(iii) The joint sponsorship program may not involve the marketing, promotions, or sale of products or services;

(iv) If in any Service area or portion thereof covered by the joint sponsorship program, a Licensee that has exclusive rights to one of the Brands (e.g. Blue Shield marks) is not participating, the participating Licensees may not use that Brand in that Service Area or portion thereof. For example, if BCBS of Geography A and Blue Cross of Geography B enter into a joint sponsorship program to be displayed in Blue Cross of Geography B's Service Area, but Blue Shield of Geography B has exclusive rights to use the Blue Shield marks in Geography B and does not participate, then the Blue Shield marks may not be used in Geography B in any manner in connections with the joint sponsorship program, not even in BCBS of Geography A's name. BCBS of Geography A may apply for approval under the BlueCross BlueShield Brand Book to adopt a shortened trade name (e.g., Blue Cross of Geography A) for use in connection with the program in Geography B, and

(v.) Subject to the limitations set forth above, the participating Licensees shall use one of the designated templates shown in Appendix C of the BlueCross BlueShield Brand Book for branding of the joint sponsorship. For clarification, the templates identified herein shall apply only to the manner in which the participating Licensees' Blue logos appear in one visual representation to identify the sponsors and does not apply to any other aspect of the sponsorship branding.

d. hosting meetings or events (collectively, "events") in Washington, D.C. or a Plan's State Capitol related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Licensed Marks and Name outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCGSA and to the local Plan(s);

e. permitting an affiliate that is not licensed to use the Licensed Names and Marks to identify its corporate relationship with the Plan pursuant to the BlueCross BlueShield Brand Book as amended by BCBSA from time to time;

*(Illustrative examples of Other Uses provisions are found on BCBSA's Brand Use Center).

1.7. Definition of Contiguous Area

For the purposes of this Exhibit, Contiguous Area means the greater of;

- One county into an adjoining Service Area; or
- An entire Metropolitan Statistical Area ("MSA") as defined by the most recent publication of the United States Department of Commerce, partly in a Licensee's Service Area and partly in portions of other Licensee(s) Service Area; or
- A larger area in an adjoining Service Area approved in advance by the Organization and Governance Committee because of unique geographical or demographic circumstance.

3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

   a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services).

   b. distributing business cards other than in marketing and selling;

   c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

   d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

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

f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;

g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.

h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]

i. contracting with a pharmacy management organization (“Pharmacy Intermediary”) to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate’s regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate’s regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate’s name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

k. contracting with a dental management organization (“Dental Intermediary”) to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate’s regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;

n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;

o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;

p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;

q. contracting with a company that makes health care professionals available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.

   a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;

   b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;

   c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third-party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

i. identification of the complaining party (or parties) requesting the proceeding;

ii. identification of the respondent(s);

iii. identification of any other persons or entities who are interested in a resolution of the dispute;

iv. a full statement describing the nature of the dispute;

v. identification of all of the issues that are being submitted for resolution;

vi. the remedy sought;

vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;

viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and

ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties):

i. a full Answer to the aforesaid Complaint;

ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;

iii. a statement as to whether the respondent elects to first pursue Mediation; and

iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties), a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

1. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.

ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross- examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.

iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediator(s), or any one or more of the selected mediators, will sit in on the negotiations.

iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.

v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.

vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.

vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediators shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

2. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as "MDR").

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or
(iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

C. Initial Conference

Within seven (7) days after a Notice of Termination has issued or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the “Initial Conference”) may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party’s ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select athree member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

iii. decide challenges as to its own jurisdiction.

iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the “Administrative Conference”). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and

how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on- site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

i. ***Requests for Production of Documents***: All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.

ii. ***Requests for Admissions***: Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

iii. ***Depositions****:* As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition1 testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.

iv. ***Expert witness(es)***: If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2) (B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.

v. ***Discovery cut-off****:* The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty
(30) days from the date of the Administrative Conference without the agreement of all parties.

Amended as of September 20, 2007

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1 As used in these Rules, "de bene esse deposition" means a deposition that is not taken for discovery purposes, but is taken for the purpose of reading part or all of the deposition transcript into the record at the Arbitration Hearing, to the extent permitted by the Panel, because the witness cannot be compelled to testify at the Arbitration Hearing or has exercised a right provided under these Rules to provide deposition testimony in lieu of testimony at the Arbitration Hearing.

vi. ***Additional discovery***: Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. ***Discovery Disputes****:* Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. ***Extensions****:* The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq*., and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq*., twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

N. Arbitration Hearing Procedures

i. ***Attendance at Arbitration Hearing***: Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.

ii. ***Confidentiality***: The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.

iii. ***Stenographic Record***: Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.

iv. ***Oaths***: The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.

v. ***Order of Arbitration Hearing***: An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

vi. ***Evidence***: The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

vii. ***Closing of Arbitration Hearing***: The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq*.

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

3. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.

ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii.), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance in Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Notwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub- sections only hereinafter referred to collectively and individually as a “Party”) that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys’ fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys’ fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant Paragraph to 3.O above with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, “legal holiday” includes New Year’s Day, Martin Luther King, Jr. Day, Washington’s Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

EXHIBIT 10.13

BLUE SHIELD LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their September 19, 2024 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Shield Plan, known as _____(the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans (unless otherwise defined in this Agreement, Plans shall mean Member Plans as that term is defined in BCBSA's Bylaws) (“Member Plans”), facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA executed the Agreement(s) Relating to the Collective Service Mark "Blue Shield"; and

WHEREAS, BCBSA and the Plan desire to supersede said Agreement(s) to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE SHIELD system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement (“Agreement” or “Primary License Agreement”), the right to use BLUE SHIELD in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Workers’ Compensation Insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms “Health Coverage”, “Eligibility” and “Enrollment” are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: (i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the agreement attached as Exhibit 1A1 hereto (the “Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products”) and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers’ Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the agreement attached as Exhibit 1 hereto (the “Controlled Affiliate License”); and iv) regional Medicare Advantage PPO Products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the agreement attached as Exhibit 1B hereto (the “Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products”); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the agreement attached as Exhibit 1C hereto (the “Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products”). A “Controlled Affiliate” is defined as an entity that meets the requirements of bona fide control stated herein and has executed a Controlled Affiliate License Agreement. Unless otherwise approved in writing by BCBSA, bona fide control shall have the meaning set forth in Paragraphs 2a and 2b. If the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons with authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that the Plan (the “Sponsoring Plan”) must have:

A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

B. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate’s establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

1. Change its legal and/or trade name;

2. Change the geographic area in which it operates;

3. Change any of the types of businesses in which it engages;

4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

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

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

C. With respect to a Controlled Affiliate that is 100% controlled by Member Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the legal authority by the Sponsoring Plan together with such other Member Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Member Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Member Plans each having an ownership interest. Such 100% control and ownership by Member Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Member Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-1 to Exhibit 1 attached hereto; or

D. With respect to a Controlled Affiliate that is 100% controlled by another Member Plan which on a Blue-branded basis within the Plan's Service Area, offers solely a Basic Medicare Part D Prescription Drug product, the legal authority by the other Member Plan (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Member Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by the Member Plan shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and Participating Plan as defined on the Controlled Affiliate License Agreement shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-2 to Exhibit 1 attached hereto.

E. With respect to a Controlled Affiliate that operates as a clinic, the legal authority by the Sponsoring Plan to exercise control over the policy and operations of the Controlled Affiliate as defined in Exhibit 1, Standard 1(E) and the Guidelines to Administer Standard 1 (E). In addition, if the clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur.

F. With respect to any Plan affiliation(s) entered into after June 15, 2023, the Plan has entered into a contractual agreement that meets the criteria set forth in Exhibit 1, Standard 1(F) and the Guidelines to Administer Standard 1(F) and Protocol for Determining Automatic Transfer of Primary License Agreement Pursuant to Contractual Control.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the "Controlling Plans"); and

B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

1. Change its legal and/or trade names;

2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Amended as of June 20, 2019

(the next page is 3)

3. With respect to an affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the affiliate and permit such affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified in the BlueCross BlueShield Brand Book consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any unlicensed affiliate to use the Licensed Marks or Name.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area", except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Shield Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

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

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) The Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination

becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an “Institutional Investor” if (but only if) such Person (i) is an entity or group identified in the SEC’s Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person’s Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) “Noninstitutional Investor” means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; (c) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and Costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association’s Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re- Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of $80. The Re-Establishment Fee through December 31, 2005 shall be $80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of the base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only

to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three- fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

(iv) The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with

BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

(v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plans Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.

(vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements of this paragraph 15(d).

(vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

(ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

Amended as of June 16, 2006

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA's Bylaws.

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By_____

Title_____

Date_____

Plan:

By_____

Title_____

Date_____

EXHIBIT 1

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
(Includes revisions adopted by Member Plans through their November 16 , 2023 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____(“Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan, known as _____("Plan" or “Sponsoring Plan”), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers’ compensation insurance, and (ii) underwriting the indemnity portion of workers’ compensation insurance, provided that Controlled Affiliate’s total premium revenue comprises less than 15 percent of the Sponsoring Plan’s net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Subject to Paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate’s governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate’s establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

Amended as of September 19, 2014

(iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;

(v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;

(vi) make any loans or advances except in the ordinary course of business;

(vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

(viii) conduct any business other than under the Licensed Marks and Name;

(ix) take any action that Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(2) The legal authority directly or indirectly through wholly-owned subsidiaries;

(a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and

c) to exercise control over the policy and operations of the Controlled Affiliate.

Amended as of March 26, 2015

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services, the Sponsoring Plan has the legal authority together with such other Plans:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute a separate Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-1 for each product noted in Paragraph 2E(3) that is licensed to use the Marks.

Or

(4) With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis offers solely a Basic Medicare Part D Prescription Drug product, the Sponsoring Plan has the legal authority:

(a) to select all members of the Controlled Affiliate's governing body; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

(c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA, Further, the Participating Plan as defined in Exhibit B-2 and the Sponsoring Plan shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-2.

Or

(5) With respect to a Controlled Affiliate that is operating as a clinic, absent an alternative method of control approved in writing by BCBSA, the Sponsoring Plan shall have bonafide operational control over the Controlled Affiliate as specified in Exhibit A, Standard 1 (E) and the Guidelines to Administer Standard 1 (E). In addition, if the clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing documents of the Controlled Affiliate with which it does not concur.

Or

(6) With respect to any Plan affiliation(s) entered into after June 15, 2023, the Controlled Affiliate has entered into a contractual agreement with the Sponsoring Plan that meets the criteria set forth in Exhibit A, Standard 1(F) and the Guidelines to Administer Standard 19F) and Protocol for Determining Automatic Transfer of Primary License Agreement Pursuant to Contractual Control.

3. FOR-PROFIT, PUBLICLY TRADED LICENSEES

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

(1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.

(2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.

(3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(4) The Controlled Affiliate's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstitutional Investor, other than a Plan or Plans or Controlled Affiliate licensee or licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a

Plan or Plans or Controlled Affiliate licensee or licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under Paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provision of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities, or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(6) For purposes of paragraph 3(A) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(3) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding", when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

Amended as of March 26, 2015

(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 1 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be

limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute

resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association’s Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate’s property or business shall not in itself be deemed to

constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any controlled Affiliates directly or indirectly owned by the terminated for profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 8(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re- Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

The Re-Establishment Fee shall be indexed to a base fee of $80. The Re- Establishment Fee through December 31, 2005 shall be $80. The Re- Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re- Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was $278.60, $285.00 and $290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be $83.27 (100% of base fee plus $1.84 for calendar year 2005 and $1.43 for calendar year 2006. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk- Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided

further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any cost associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3.and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term ‘Plans’ shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA’s Bylaws.

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Plan:

By:_____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
November 2023
PREAMBLE

For purposes of definition:

- A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.

- A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA “Health Risk-Based Capital (HRBC)” as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and

2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers’ compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

EXHIBIT A (continued)

EXHIBIT A (continued)

Matrix to Determine which Standards for Licensed Controlled Affiliates Apply

Each licensed Controlled Affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed Controlled Affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan ⇩ Standard 1A Or Contractual Control ⇩ Standard 1F	50% by Sponsoring Plan ⇩ Standard 1B	100% Plan Control but less than 50% Sponsoring Plan Control and it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services ⇩ Standard 1C	100% Sponsoring Plan control and on a Blue- branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product ⇩ Standard 1D	At least 50% by Sponsoring Plan or operational Control by Sponsoring Plan and it solely operates as a Clinic as defined in Standard 1E ⇩ Standard 1E

IN ADDITION,

2. Is risk being assumed?

Yes			No	
⇙	⇩	⇘	⇙	⇩
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance ⇩ Standards 6A- 6E, 9	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ⇩ Standard 2 (Guidelines 1.1,1.2) and Standard 9	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ⇩ Standard 5E	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ⇩ Standard 2 (Guidelines 1.1,1.3) and Standard 9	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ⇩ Standard 5E

IN ADDITION,

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

Yes	No
⇩	⇩
Standard 3A	Standard 3B

Matrix to Determine which Standards for Licensed Controlled Affiliates Apply

Each licensed Controlled Affiliate shall be subject to certain standards as determined below:

IN ADDITION,

4. Is the licensed Controlled Affiliate operating as a Clinic as defined in Standard 1(E)?

Yes
⇩
Standard 3C and Standard 2, 1.4 (if organized as a health plan that also operates as a Clinic)

1. If the Controlled Affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?

Yes	No		
⇩	⇙	⇙	⇘
Standards 5A-5F	Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C)	Controlled Affiliate is a former primary licensee	Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C)
	⇩	⇩	⇩
	Standards 4,7,8B,9	Standards 4,7,8A,9	Standards 4,7,8B,9

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA , has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority, directly or indirectly through wholly-owned subsidiaries:

1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business

- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

1C.) The Standard for a Controlled Affiliate that offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and service and has 100% Plan control but less than 50% Sponsoring Plan Control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA has the legal authority together with Other Plans:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for- profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

EXHIBIT A (continued)

1D.) The Standard for a Controlled Affiliate that on a Blue-branded basis only offers a Basic Medicare Part D Prescription Drug Plan product and has 100% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) on a Blue-branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product; and (ii) the Sponsoring Plan has the legal authority:

1) to select all members of the Controlled Affiliate's governing body; and

2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and

3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA.

Further, the Sponsoring Plan and Participating Plan shall execute the Addendum to Controlled Affiliate License.

1E.) The Standard for a Controlled Affiliate that operates as a Clinic and the Sponsoring Plan has control of the Clinic is:

A Controlled Affiliate shall be organized in such a manner that it operates as a Clinic and the Sponsoring Plan exercises operation control over the Controlled Affiliate.

In addition, if the Clinic is for-profit, the Sponsoring Plan shall own at least 50% of the Controlled Affiliate and prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate.

1F.) The Standard for possessing contractual control over a Controlled Affiliate is:

With respect to any Plan affiliations entered into after June 15, 2023, a Primary Licensee has entered into a contractual agreement where:

(i) It has outsourced 50% or more of the expenditures for overall management and strategic direction to another Primary Licensee, or

(ii) A regulatory agency has determined that a change of control or a corporate affiliation has occurred, or

(iii) Officers of a Primary Licensee perform roles for another Primary Licensee.

(This excludes Controlled Affiliates pursuant to paragraphs 2(a)(C) and 2(a)(D) of the Primary License Agreement).

The Primary License Agreement will automatically transfer, and the Plan will automatically become a Controlled Affiliate of the other Primary Licensee unless otherwise approved in writing by BCBSA.

Amended September 19, 2024

EXHIBIT A (continued)

Standard 2 – Financial Responsibility

Standard is:

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Shield Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, the Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specifically exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 – State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

3C.) The Standard for a Controlled Affiliate that operates as a Clinic as defined in Standard 1(E) is:

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

Standard 4 – Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Amended as of September 19, 2024

EXHIBIT A (continued)

Standard 5 – Other Standards for Larger Controlled Affiliates
Standards 5(A) – (F) that follow apply to larger Controlled Affiliates.

Standard 5(A): Board of Directors The Standard is:
A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members[1]. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 5(B): Responsiveness to Customers The Standard is:
A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 5(C): Participation in National Programs The Standard is:
A Controlled Affiliate shall effectively and efficiently participate in Inter-Plan Programs, including, but not limited to the BlueCard Program and Inter-Plan Medicare Advantage Program, for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area. Controlled Affiliates must also participate in Business Associate Agreement for Blue Cross and Blue Shield Licensees .

Standard 5(D): Local Best Efforts The Standard is:
Notwithstanding any other provision in the Plan’s License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross [applicable to Blue Cross Licensees] and Blue Shield [applicable to Blue Shield Licensees] Marks.

Standard 5(E): Financial Responsibility The Standard is
A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers and shall take such action as required to ensure its financial performance in programs and contracts of an inter- licensee nature or where BCBSA is a party (formerly Standard 6(D)). A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose (formerly Standard 6(F)).

Amended as of September 19, 2024

[1] A "public member" excludes any person who:
1. is engaged or has engaged at any time in the practice of a health care profession (other than an employee of the Plan);
2. is a director, officer, partner or employee of an organization that primarily sells health care services (other than the Plan or an organization controlled by the Plan); or
3. is a director, officer, partner or employee of an organization of health care providers; or
4. has direct or indirect beneficial interest of more than five percent of the equity of an organization that sells or delivers health care services.

EXHIBIT A (continued)

Standard 5(F): Control by Unlicensed Entities Prohibited The Standard is:
No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 6 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates
Standards 6(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 6(A): Financial Responsibility The Standard is:
A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 6(B): Reports and Records The Standard is:
A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

A. BCBSA Controlled Affiliate Licensure Information Request; and

B. Triennial trade name and service mark usage materials, including disclosure material; and

C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and

D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports*; and

F. Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter**, articles of incorporation***, or bylaws**, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care*.

Standard 6(C): Loss Prevention The Standard is:
A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Amended as of September 19, 2024

* Submit within 30 days of change to: Associate General Counsel, Licensure, Blue Cross and Blue Shield Association, 200 East Randolph Street, Suite 1800, Chicago, IL 60601
** Include a red-lined version that clearly identifies the changes

EXHIBIT A (continued)

Standard 6(D): Claims Administration The Standard is:
A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 6(E): Disability and Provider Management The Standard is:
A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Standard 7 – **Cooperation with Controlled Affiliate License Performance Response Process Protocol**
The Standard is:
A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Organization and Governance Committee in the Administration of the Controlled Affiliate Licensee Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 8 – **Participation in National Programs by Smaller Controlled Affiliates** Standard 8(A): Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees
The Standard is:
A smaller Controlled Affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in Inter-Plan Programs, including, but not limited to the BlueCard Program and Inter-Plan Medicare Advantage Program, for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. Financial Requirements include:
   - Standard 5(E): Financial Responsibility; or
   - A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

B. Reporting requirements include:
   - Semi-annual Health Risk-Based Capital (HRBC) Report as defined by the NAIC.

Standard 8(B): Participation in National Programs by Smaller Controlled Affiliates The Standard is:
A smaller Controlled Affiliate shall effectively and efficiently participate in Inter-Plan Programs, including, but not limited to the BlueCard Program and Inter-Plan Medicare Advantage Program, for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. Financial Requirements include:
1. Standard 5(E): Financial Responsibility; or
2. A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

EXHIBIT A (continued)

Standard 9: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees
The Standard is:
Effective April 14, 2003, all smaller Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B-1

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Shield Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____("Controlled Affiliate Licensee") and _____("Sponsoring Plan") dated the _____ day of _____, _____ ("Agreement"). The parties to this Addendum are licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ('Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans market in its Service Area more efficiently and with less risk through an enterprise jointly owned and controlled with other Plans than through a wholly owned and Controlled Affiliate Licensee;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. This Addendum is limited to [identify product name].

2. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid, Medicare Advantage PPO, Medicare Advantage HMO and/or Special Need Plans services being offered under the Agreement and being involved in network development and provider engagement functions.

3. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it

will not take any action, either individually or jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

4. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 8 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By:_____

[Controlled Affiliate Licensee]

By:_____

[Sponsoring Plan]

By:_____

[Other Plan 1]

By:_____

[Other Plan 2]

By:_____

Amended as of September 27, 2018

EXHIBIT B-2

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1D.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Shield Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____("Controlled Affiliate Licensee"), _____("Sponsoring Plan") and _____ ("Participating Plan") dated the _____ day of _____, _____ ("Agreement").

WHEREAS, the Participating Plan is defined as the Plan that holds the Primary License with BCBSA to use the Service Marks in the Service Area where the Controlled Affiliate will use the Service Marks;

WHEREAS, the Participating Plan asserts that it can offer a lower cost Basic Medicare Part D Prescription Drug Plan product more efficiently in the Participating Plan's Service Area through the Controlled Affiliate Licensee;

WHEREAS, the Controlled Affiliate shall only use the Service Marks inside of the Participating Plan(s) Service Area subject to each Participating Plan signing a separate Addendum;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1D permits the licensing of a Controlled Affiliate that is 100% owned and controlled by a Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan, Controlled Affiliate and the Participating Plan enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Participating Plan shall participate in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that the Participating Plan shall conduct sales support and marketing of the Controlled Affiliate's Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area. Any other form of participation shall require BCBSA's written approval.

2. Participating Plan agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with the Sponsoring Plan or Controlled Affiliate Licensee, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. The Controlled Affiliate Licensee shall only use the Licensed Marks authorized by the Participating Plan in connection with the Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area.

4. The Sponsoring Plan and Controlled Affiliate acknowledge that it has reviewed the Agreement and understands that Participating Plan has the right to terminate this Agreement: (i) immediately upon the expiration or termination of the Plan Participation Agreement by and between Participating Plan and Controlled Affiliate upon written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, or (ii) without cause upon 18 months written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, and that such right is unfettered and may be exercised by Participating Plan in its sole discretion. In the event that Participating Plan and Controlled Affiliate fail to execute the Plan Participation Agreement by _____ (Date), Participating Plan may terminate this Agreement immediately upon notice to Sponsoring Plan, Controlled Affiliate Licensee and Licensor.

5. This Agreement and all of Controlled Affiliate Licensee's rights hereunder shall immediately terminate without any further action by any party or entity in the event that the Sponsoring Plan or Participating Plan ceases to be authorized to use the Licensed Marks and Name.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Participating Plan]

By: _____

Amended March 17, 2016

EXHIBIT C

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 7.

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third-party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

1) An annual fee of $5,000 per license for a Controlled Affiliate subject to Standard 6 D.

2) An annual fee of $2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

EXHIBIT 1A

CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO LIFE INSURANCE COMPANIES

(Includes revisions adopted by Member Plans through their November 16, 2023 meeting)

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA") _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan(s), known as _____ ("Plan").

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Shield Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Shield Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

An annual fee of five thousand dollars ($5,000) per license, plus

.05% of gross revenue per year from branded group products, plus

.5% of gross revenue per year from branded individual products plus

.14% of gross revenue per year from branded individual annuity products.

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA's Bylaws.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

Controlled Affiliate

By:_____

Date:_____

Plan

By:_____

Date:_____

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to- time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 – Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 – State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

Standard 3 – Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement. The LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 – Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 – Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 – Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Organization and Governance Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

Exhibit 1A1

CONTROLLED AFFILIATE TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILTY INSURANCE PRODUCTS

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, ("Life and Disability Controlled Affiliate") which is a company offering life and disability insurance products owned and controlled by _____, _____,_____(individually, "Sponsoring Plan" and when referred to collectively, "Sponsoring Plans").

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof ("Licensed Marks");

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans' Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, ("Blue Plans") consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3) Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing ("Licensed Products") in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to "Consenting Plan(s)") must clearly identify the Consenting Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan's existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(5) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

15. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly- owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance

thereof; and to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate’s conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or

(2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or

(3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars ($5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA's Bylaws.

Amended as of June 15, 2023

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

Life and Disability Controlled Affiliate:

By:_____

Date:_____

Sponsoring Plan:

By:_____

Date:_____

Name:_____

Sponsoring Plan:

By:_____

Date:_____

Name:_____

[Add other Sponsoring Plans as necessary]

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS

Standard 1 – Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 – State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 – Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 – Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then- current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS

Standard 5 – Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 – Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Organization and Governance Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B

CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ ("Life and Disability Controlled Affiliate"), and the Blue Cross and Blue Shield Association ("BCBSA") and shall be deemed effective on _____ ("Effective Date").

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the "Brands");

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area ("Service Area");

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products ("Products") as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products ("Life and Disability License Agreement");

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan's Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate's use of the Brands in Blue Plan's Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan's Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan's license agreement(s) with BCBSA. Life and Disability Controlled Affiliate's rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.

2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales, marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

   _____

5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;

6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.

9. This Consent Agreement may be terminated as follows:

   A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;

   B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or

   C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.

10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by: [Blue Plan]:

By:_____

Title:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By:_____

Title:_____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By:_____

Title:_____

Exhibit 1B

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their November 16, 2023 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time- to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph (E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7I and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association’s Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate’s property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of paragraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and

any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other

Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the

Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term ‘Plans’ shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA’s Bylaws.

Amended as of June 15, 2023

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

EXHIBIT A

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

November 2023 PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly- owned subsidiaries:

   (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

   (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

   (c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and

b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

a. Inter-Plan Teleprocessing System (ITS); and

b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

Exhibit 1C

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS
(Adopted by Member Plans at their November 16, 2023 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ (“Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services (“CMS”) to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter “regional PDP products”).

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states:
_____ (the “Region”). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time- to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to

complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim

trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to $25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license

termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, voting shall occur pursuant to BCBSA's Bylaws.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

Amended as of June 15, 2023

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By:_____

Date:_____

Controlling Plan:

By: _____

Date:_____

Controlling Plan:

By: _____

Date:_____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By:_____

Date:_____

EXHIBIT A

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

November 2023

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly- owned subsidiaries:

   (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;

   (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

   (c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

a. the structure of the Blue Cross and Blue Shield System; and

b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a “Shell Holding Company” is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a “Hybrid Holding Company” is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1: A Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 2: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers and shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party (formerly Standard 6.) Annually a Plan, excluding a Shell Holding Company, shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose (formerly Standard 9).

Standard 3: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 4: A Plan shall effectively and efficiently participate in Inter-Plan Programs, including, but not limited to the BlueCard Program and Inter-Plan Medicare Advantage Program, for the purposes of providing portability of membership between Plans and ease of claims processing for customers receiving benefits outside of Control/Home Plan's Service Area.

Standard 5: Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Cross [for Blue Cross Licensees] and Blue Shield [for Blue Shield Licensees] Marks.

Standard 6: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services if such control or acquisition has the potential to impair (1) the value of the Blue Marks or (2) the competitiveness or efficiency of Blue Branded business or the Blue Marks.

Standard 7: No provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.

Standard 8: Each Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

EXHIBIT 3

GUIDELINES WITH RESPECT TO USE OF
LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS

1. The strength of the Blue Cross/Blue Shield National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends. The policies and provisions governing National Accounts, including but not limited to the Inter- Plan Programs Policies and Provisions, are incorporated by reference into these guidelines. If there is a conflict between these guidelines and the policies and provisions governing National Accounts, the policies and provisions control the resolution of such conflict.

2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. Unless otherwise provided in the policies and provisions governing an applicable National Account, the Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.

3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.

4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 24, 2024

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by MSC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of applicable
Inter-Plan Programs.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

1. A Plan and its licensed Controlled Affiliate(s) “Licensees” may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. Licensees may NOT use the Brands in communications or transactions with beneficiaries or providers in a Government program located outside its Service Area. For purposes of this Paragraph 1, the term “Government Programs” shall mean any non-risk Medicare, Medicaid, and other non-risk program administered by a government authority, and any successor program. Contracts with the United States Government or the Government of a State or Municipality to provide health care coverage to its employees are not considered Government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, Licensees, except for Regional MA PPO and PD Controlled Affiliates (see paragraph 3 below), may use the Licensed Marks and Name (also referred to as “Brands”) outside the Licensee’s Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

   a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);

   b. distributing business cards other than in marketing and selling;

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

2.2 Marketing Spillover

a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Licensee, provided that no Licensee may advertise outside its Service Area on the national broadcast or cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Licensee's Service Area;

2.3 Provider Contracting

a. contracting with health care providers or soliciting such contracts in a Contiguous Area in order to serve its subscribers residing or working in its service area;

b. issuing a small sign containing the legal name or trade name of the Licensee for display by a provider in a Contiguous Area to identify the provider as a participating provider of the Licensee;

c. negotiating case-specific reimbursement rates with a provider that does not have a contract applicable to a specific member's services rendered or to be rendered with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located, so long as

(1) the Licensee engaging in the negotiations complies with all applicable Inter- Plan Programs Policies and Provisions and Brand Regulations related to case- specific rate negotiations, and

(2) the Licensee (or all Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located provides consent before negotiations commence.

d. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Licensee's members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network.

e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Licensee's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;

f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Licensee's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

(i) For purposes of this Exhibit, "routine dental benefit" covers four classes of dental services: (1) preventative services (e.g., teeth cleaning, oral exams, x-ray and lab exams); (2) restorative services (e.g. fillings, crowns, inlays/onlays, root canal, periodontal treatments, extractions, repairs to partials); (3) construction of dentures and bridges; and (4) orthodontic tooth guidance appliances (e.g., braces, habit-breaking appliances).

(ii) Examples of services that are not within the scope of "routine dental" include any medical oral or maxillofacial procedures, including maxillofacial surgery, and diagnosis or treatment of the oral or maxillofacial region as a result of disease, chronic illness, or injury.

g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Licensee's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

(i) For purposes of this Exhibit, "routine vision benefit" covers routine eye exams, glasses (frames and lenses), contact lenses, and Lasik surgery.

(ii) Examples of services that are not within the scope of "routine vision" include any medical vision procedures, including eye surgery, and the diagnosis or treatment of the eye as a result of disease, chronic illness, or injury.

h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Licensee's Service Area;

i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Licensee's Service Area;

j.

k. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Licensee's Service Area;

l. contracting with a company that operates provider sites in the Licensee's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Licensee's Service Area;

m. contracting with a company that makes health care professionals available in the Licensee's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Licensee's Service Area.

n. Permitting Control/Home Plans' ability to resolve members' service issues requiring outreach to out-of-area providers as set forth in the Inter-Plan Programs and Inter- Plan Medicare Advantage Program Policies.

o. contracting with national telemedicine and virtual healthcare (i.e., telehealth providers) companies nationally for all virtual-only health care services in accordance with Inter-Plan Programs and Inter-Plan Medicare Advantage Policies and Provisions.

2.4 Services to National Accounts

a. when applicable Inter-Plan Programs Policies and Provisions ("IP Policies") specifically permit a Plan to contract with a National Account headquartered outside of a Plan's Service Area to offer Blue-branded Health Coverage to the National Account. Nothing in this rule 2.4 supersedes the IP Policies.

b. in conjunction with contracting with a National Account as offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:

(i) the Licensee has no contact or interaction with providers outside of the Licensee's Service Area, except as specifically provided in the IP Policies and in 2.4(c); and

(ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Licensed Marks and Name a local plant, office or division of the account that is outside of the Control/Alternate Licensee's Service Area, the Control/Alternate Licensee may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and

(iii) if the Licensee provides an information card to the non-Blue Health Coverage members, the card may not display the Licensed Marks in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

2.4 Services to National Accounts (continued)

For purposes of this subparagraph b, and below subparagraph c, the following definitions apply:

"Health and Wellness Program" shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

"Health Coverage" shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

c. as part of a Health and Wellness Program that is otherwise compliant with subparagraph b above, contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event ("Event") held at a National Account's worksite outside of the Licensee's Service Area, provided that:

   (i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and

   (ii) neither such services nor their costs are applied as claims against any benefit plan; and

   (iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite.

d. in conjunction with contracting with a National Account to offer Blue branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan and/or licensed Controlled Affiliate, provided that:

   (i) in performing such functions, Licensee does not use the Licensed Marks and Name in any communications with health care providers outside of the Licensee's Service Area, and otherwise limits its use of the Licensed Marks and Name outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and

   (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Licensed Marks and Name a local plant, office or division of the account that is outside of the Plan's Service Area, Licensee may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

e. in conjunction with contracting with a National Account to perform or investigate fraud, waste and abuse investigation activities for a non-participating provider in a Par/Host Plan's service area, as long as the Control/Home Plan is given permission to do so by the Par/Host Plan and specific conditions are met in accordance with Inter-Plan Programs and Inter-Plan Medicare Advantage Program policies.

For purposes of this Exhibit, the following definitions apply:

"Eligibility" means services that manage the account's eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of "hour-banking" for union environments in which union members can bank hours to remain eligible for benefits.

"Enrollment" means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account's benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account's benefit plan providers;
- review and reconciliation of error reports received from the account's benefit plan providers; and
- transmission of information to the account's payroll system (e.g., benefit deductions, employee demographic data).

2.5 Conferences and Symposiums

a. submitting scholarly articles authored or co-authored by the Licensee or its respective employees for publication in peer-reviewed journals (see BCBSA's Brand Use Center);

b. permitting an internal representative of the Licensee to participate at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee and/or the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee and/or the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website. A participating Licensee will also be permitted to display/share communications at the conference or symposium subject to the requirements set forth in (c) below.

c. Participating in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services unless there is a clear connection between the Licensee and the reasoning for attending such conference or symposium (e.g., health care decision makers within the Licensee's service area will also be at the conference, the conference has a nexus to the Licensee's service area even though the conference is taking place elsewhere) and the Licensee has provided BCBSA with advanced written notice prior to participating.

(i) Licensees may establish a booth to support at Conferences or Symposiums consistent with the above. Any materials containing the Brands must include a disclosure clearly indicating the Licensee's name or trade name as well as an indication of where the Licensee provides products and services (i.e. BCBS of Geography)

(ii) Licensees may not co-exhibit or promote the products and/or services of an unlicensed affiliate.

2.6 Other Uses*

a. entering into a license agreement between and among BCBSA, the Licensee and a debit card issuer located outside the Licensee's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;

b. appearing in communications issued by an independent third party to recognize outstanding performance of the Licensee or a member of the Licensee's senior management as part of an established program of the third party for which the Licensee has provided information to be considered for the recognition The areas of recognition must relate to a Licensee's performance as an employer or corporate citizen, or for a corporate business function other than sales or marketing (e.g. human resources, underwriting). The third party's communication of the recognition must appear only in its customary media and form used with the established program.

c. to identify itself as being a joint sponsor of an event, program or activity (e.g., a 5k run, a public event, a wellness education seminar) along with other Licensees provided that the following conditions are met:

(i) Written notification is provided to BCBSA staff at least 30 days before the event or when the Licensee executes a sponsorship agreement, whichever is earlier, identifying the joint sponsorship opportunity and the participating licensees, and including a sample of the proposed branding consistent with the template that is required under 2.6(c)(v).

(ii) Communications and materials relating to such joint sponsorship may appear solely within the Service Areas of Licensees who have provided prior consent, are participating in such joint sponsorship program and whose names appear in such communications and materials. In each participating Licensee's Service Area, such participating Licensee's name must appear in all such communications and materials with at least equal prominence as the names of other listed participating Licensees;

(iii) The joint sponsorship program may not involve the marketing, promotions, or sale of products or services;

(iv) If in any Service area or portion thereof covered by the joint sponsorship program, a Licensee that has exclusive rights to one of the Brands (e.g. Blue Shield marks) is not participating, the participating Licensees may not use that Brand in that Service Area or portion thereof. For example, if BCBS of Geography A and Blue Cross of Geography B enter into a joint sponsorship program to be displayed in Blue Cross of Geography B's Service Area, but Blue Shield of Geography B has exclusive rights to use the Blue Shield marks in Geography B and does not participate, then the Blue Shield marks may not be used in Geography B in any manner in connections with the joint sponsorship program, not even in BCBS of Geography A's name. BCBS of Geography A may apply for approval under the BlueCross BlueShield Brand Book to adopt a shortened trade name (e.g., Blue Cross of Geography A) for use in connection with the program in Geography B, and

(v.) Subject to the limitations set forth above, the participating Licensees shall use one of the designated templates shown in Appendix C of the BlueCross BlueShield Brand Book for branding of the joint sponsorship. For clarification, the templates identified herein shall apply only to the manner in which the participating Licensees' Blue logos appear in one visual representation to identify the sponsors and does not apply to any other aspect of the sponsorship branding.

d. hosting meetings or events (collectively, "events") in Washington, D.C. or a Plan's State Capitol related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Licensed Marks and Name outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCGSA and to the local Plan(s);

e. permitting an affiliate that is not licensed to use the Licensed Names and Marks to identify its corporate relationship with the Plan pursuant to the BlueCross BlueShield Brand Book as amended by BCBSA from time to time;

*(Illustrative examples of Other Uses provisions are found on BCBSA's Brand Use Center).

2.7. Definition of Contiguous Area

For the purposes of this Exhibit, Contiguous Area means the greater of;

- One county into an adjoining Service Area; or
- An entire Metropolitan Statistical Area ("MSA") as defined by the most recent publication of the United States Department of Commerce, partly in a Licensee's Service Area and partly in portions of other Licensee(s) Service Area; or
- A larger area in an adjoining Service Area approved in advance by the Organization and Governance Committee because of unique geographical or demographic circumstance.

3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

   a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services).

   b. distributing business cards other than in marketing and selling;

   c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

   d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;

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

f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;

g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.

h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]

i. contracting with a pharmacy management organization (“Pharmacy Intermediary”) to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate’s regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate’s regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate’s name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

k. contracting with a dental management organization (“Dental Intermediary”) to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate’s regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;

n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;

o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;

p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;

q. contracting with a company that makes health care professionals available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.

   a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;

   b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;

   c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third-party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

Amended as of June 15, 2023

MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

i. identification of the complaining party (or parties) requesting the proceeding;

ii. identification of the respondent(s);

iii. identification of any other persons or entities who are interested in a resolution of the dispute;

iv. a full statement describing the nature of the dispute;

v. identification of all of the issues that are being submitted for resolution;

vi. the remedy sought;

vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;

viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and

ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties):

i. a full Answer to the aforesaid Complaint;

ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;

iii. a statement as to whether the respondent elects to first pursue Mediation; and

iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties) a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.

ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross- examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.

iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediators, or any one or more of the selected mediator(s), will sit in on the negotiations.

iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.

v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.

vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.

vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediator(s) shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as "MDR").

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

C. Initial Conference

Within seven (7) days after a Notice of Termination has issued, or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the “Initial Conference”) may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party’s ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes, and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.

iii. decide challenges as to its own jurisdiction.

iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the “Administrative Conference”). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking

of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

i. ***Requests for Production of Documents***: All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.

ii. ***Requests for Admissions***: Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

iii. ***Depositions:*** As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition[2] testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.

iv. ***Expert witness(es)***: If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.

v. ***Discovery cut-off****:* The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

Amended as of September 20, 2007

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2 As used in these Rules, "de bene esse deposition" means a deposition that is not taken for discovery purposes, but is taken for the purpose of reading part or all of the deposition transcript into the record at the Arbitration Hearing, to the extent permitted by the Panel, because the witness cannot be compelled to testify at the Arbitration Hearing or has exercised a right provided under these Rules to provide deposition testimony in lieu of testimony at the Arbitration Hearing.

vi. ***Additional discovery***: Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. ***Discovery Disputes:*** Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. ***Extensions:*** The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq*., and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

N. Arbitration Hearing Procedures

i. ***Attendance at Arbitration Hearing***: Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.

ii. ***Confidentiality***: The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.

iii. ***Stenographic Record***: Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.

iv. ***Oaths***: The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.

v. ***Order of Arbitration Hearing***: An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

vi. ***Evidence***: The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

vii. ***Closing of Arbitration Hearing***: The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq*.

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.

ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance In Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Notwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub-sections only hereinafter referred to collectively and individually as a "Party") that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys' fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys' fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant to Paragraph 3.O above, with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, “legal holiday” includes New Year’s Day, Martin Luther King, Jr. Day, Washington’s Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

EXHIBIT 19.1

INSIDER TRADING POLICY

1. Introduction

This Insider Trading Policy (this "Policy") provides guidelines to all directors, officers and associates of Elevance Health, Inc. and its subsidiaries (together referred to as "Elevance Health" or the "Company") with respect to transactions in Elevance Health's common stock and other securities. You are individually responsible for complying with this Policy.

Securities laws prohibit anyone from purchasing or selling a company's securities while aware of material nonpublic information relating to that company, or disclosing material nonpublic information to others who then trade in the securities of the applicable company. Elevance Health has adopted this Policy to promote compliance with insider trading laws and to help Elevance Health personnel avoid the severe consequences associated with violations of those laws. This Policy also is intended to prevent even the appearance of improper conduct on the part of anyone employed by or associated with Elevance Health.

2. The Consequences

Insider trading violations are pursued vigorously by the Securities and Exchange Commission ("SEC") and the U.S. Attorneys, and the consequences of an insider trading violation can be severe. An individual (or their tippee) who trades on inside information may be subject to severe civil and criminal penalties—including significant monetary fines and a prison sentence. If Elevance Health and its supervisory personnel fail to take appropriate steps to prevent illegal insider trading, they may also be subject to significant civil and criminal penalties.

Furthermore, failure to comply with this Policy may result in Company-imposed sanctions, including dismissal for cause, whether or not the individual's failure to comply results in a violation of law. Needless to say, a violation of law, or even an SEC investigation that does not result in prosecution, can tarnish a reputation and irreparably damage a career.

3. Statement of Policy

It is the policy of Elevance Health that no director, officer or associate of Elevance Health who is aware of material nonpublic information relating to Elevance Health may, directly or indirectly through family members or other persons or entities, (a) buy or sell securities of Elevance Health (including common stock, preferred stock, debt and convertible securities of the Company and derivatives (whether or not issued by the Company) linked to or exercisable for securities of the Company) ("Elevance Health Securities") (other than pursuant to a Rule 10b5-1 compliant trading plan, as discussed below) or engage in any other action to take personal advantage of that information, or (b) pass that information on to others, including family and friends, except for persons within the Company or third party agents of the Company whose positions require them to know it. In addition, no individual who, in the course of working for Elevance Health, learns of material nonpublic information about another company, including a customer or supplier, may trade

in that company's securities or pass that information on to others outside Elevance Health until the information becomes public or is no longer material.

This Policy also applies to your family members who reside with you, anyone else who lives in your household, and any family members who do not live in your household but whose transactions in Elevance Health Securities are directed by you or are subject to your influence or control (such as parents or children who consult with you before they trade in Elevance Health Securities). You are responsible for the transactions of these other persons and therefore should make them aware of the need to confer with you before they trade in Elevance Health Securities.

Transactions that may be necessary or justifiable for independent reasons (such as the need to raise money for an emergency expenditure) **are not excepted** from this Policy. The securities laws do not recognize such mitigating circumstances, and, in any event, even the appearance of an improper transaction must be avoided to preserve Elevance Health's reputation for adhering to the highest standards of conduct.

Additional restrictions on buying, selling or engaging in other transactions in Elevance Health Securities apply to members of the Elevance Health, Inc. board of directors ("Directors"), executive officers and other Designated Insiders (defined below).

4. Definitions and Explanations

Material Information

Material information generally means any information that a reasonable investor would consider important in making a decision to buy, hold, or sell securities. Any information that could be expected to affect Elevance Health's stock price, whether it is positive or negative, should be considered material. There is no bright-line standard for assessing materiality; rather, materiality is based on an assessment of all of the facts and circumstances. Some examples of information that ordinarily could be regarded as material are:

- Projections of future earnings or losses, or other earnings guidance, changes to previously announced earnings guidance, or the decision to suspend earnings guidance;
- Earnings that are inconsistent with the consensus expectations of the investment community;
- A pending or proposed joint venture, merger, acquisition or tender offer;
- A pending or proposed acquisition or disposition of a significant asset;
- A change in dividend policy, the declaration of a stock split, or an offering of additional securities;
- A change in executive management;
- Development of a significant new product or service;
- Occurrence of a significant cybersecurity incident, such as a data breach, or any other significant disruption in the Company's operations or loss, potential loss, breach or

unauthorized access of its property or assets, whether at its facilities or through its information technology infrastructure;

- Impending bankruptcy or the existence of severe liquidity problems;
- The gain or loss of a significant customer or supplier;
- Material increases or decreases in sales or margins; and
- The commencement, status or results of significant regulatory or legal proceedings.

Twenty-Twenty Hindsight

Remember, anyone scrutinizing your transactions will be doing so after the fact, with the benefit of hindsight. As a practical matter, before engaging in any transaction, you should carefully consider how enforcement authorities and others might view the transaction in hindsight.

When Information is "Public"

If you are aware of material nonpublic information, you may not trade until the information has been disclosed broadly to the marketplace (such as by a press release or an SEC filing) and the investing public has had time to absorb the information fully. To avoid the appearance of impropriety, as a general rule, information should not be considered fully absorbed by the marketplace until the first full business day after the information is released. If, for example, Elevance Health were to make an announcement before the stock market opens on a Monday, you should not trade in Elevance Health Securities until Tuesday. If an announcement is made after the stock market opens on Monday, Wednesday generally would be the first eligible trading day.

Quarterly Blackout Periods and Designated Insiders

Section 16 Officers, Directors and any associates informed by the Shareholder Services Department that they are designated insiders (collectively, "Designated Insiders") are prohibited from trading in or gifting Elevance Health Securities during the Company's regularly scheduled quarterly blackout period (commencing on the fifteenth day of the last month of Elevance Health's fiscal quarter and ending the first full business day following Elevance Health's issuance of its quarterly earnings release). "Section 16 Officers" are officers of Elevance Health, Inc. who are required under Section 16 of the Exchange Act to file trade reports on Forms 4 and 5.

Event-Specific Blackout Periods

From time to time, an event may occur that is material to Elevance Health and is known by only a few directors, officers or associates. So long as the event remains material and nonpublic, those individuals may not trade in or gift Elevance Health Securities. The existence of an event-specific blackout will not be announced, other than to those who are aware of the event giving rise to the blackout. Any person made aware of the existence of an event-specific blackout should not disclose the existence of the blackout to any other person.

5. Transactions Under Company Plans

Stock Option Exercise

This Policy **does not** apply to the exercise of an employee stock option, or to the exercise of a tax withholding right pursuant to which you elect to have Elevance Health withhold shares subject to an option or pursuant to the vesting of restricted stock in order to satisfy tax withholding requirements. This Policy **does** apply, however, to any sale of stock as part of a broker-assisted cashless exercise of an option, or any other market sale for the purpose of generating the cash needed to pay the exercise price of an option.

Restricted Stock Awards

This Policy **does not** apply to the vesting of restricted stock, or the exercise of a tax withholding right pursuant to which you elect to have the Company withhold shares of stock to satisfy tax withholding requirements upon the vesting of any restricted stock. The Policy **does** apply, however, to any market sale of restricted stock.

401(k) Plan

This Policy **does not** apply to purchases of Elevance Health stock in the Company's 401(k) plan resulting from your periodic contribution of money to the plan pursuant to your payroll deduction election. This Policy **does** apply, however, to certain elections you may make under the 401(k) plan, including (a) an election to increase or decrease the percentage of your periodic contributions that will be allocated to the Elevance Health stock fund, (b) an election to increase or decrease your periodic contributions to the 401(k) plan if you participate in the Elevance Health stock fund, (c) an election to make an intra-plan transfer of an existing account balance into or out of the Elevance Health stock fund, (d) an election to make a rollover deposit from another retirement plan into the Elevance Health stock fund in the 401(k) plan, (e) an election to borrow money against your 401(k) plan account if the loan will result in a liquidation of some or all of the Elevance Health stock fund balance, and (f) your election to pre-pay a plan loan if the pre-payment will result in allocation of loan proceeds to the Elevance Health stock fund.

Employee Stock Purchase Plan

This Policy **does not** apply to purchases of Elevance Health stock in the employee stock purchase plan resulting from your periodic contribution of money to the plan pursuant to your payroll deduction election. This Policy **does** apply, however, to certain elections you make under the plan, including, an election to increase or decrease the percentage of your periodic contributions to the plan after your enrollment in the plan, and to your sales of Elevance Health stock purchased pursuant to the plan.

6. Special and Prohibited Transactions

Elevance Health has determined that there is a heightened legal risk and/or appearance of improper or inappropriate conduct if the persons subject to this Policy engage in certain types of transactions. It therefore is Elevance Health's policy that that persons covered by this Policy may not engage in short sales, publicly traded options and hedging transactions, as described below. In addition, Section 16 Officers, Directors and Designated Insiders may not engage in margin accounts and pledging, as described below.

Short Sales

Short sales of Elevance Health Securities evidence an expectation on the part of the seller that the securities will decline in value, and therefore signal to the market that the seller has a lack of confidence in Elevance Health or its short-term prospects. In addition, short sales may reduce the seller's incentive to improve Elevance Health's performance. For these reasons, short sales of Elevance Health Securities are prohibited by this Policy. In addition, Section 16(c) of the Securities Exchange Act of 1934 ("Exchange Act") prohibits Section 16 Officers and Directors from engaging in short sales.

Publicly Traded Options

A transaction in options is, in effect, a bet on the short-term movement of Elevance Health's stock and therefore creates the appearance that the director, officer or other associate is trading based on inside information. Transactions in options also may focus the Director's, officer's or other associate's attention on short-term performance at the expense of Elevance Health's long-term objectives. Accordingly, transactions in puts, calls or other derivative securities, on an exchange, in any other organized market or otherwise, are prohibited by this Policy.

Hedging Transactions

Certain forms of hedging or monetization transactions, such as zero-cost collars and forward sale contracts, allow an individual to lock in much of the value of their stock holdings, often in exchange for all or part of the potential for upside appreciation in the stock. These transactions allow a director, officer or other associate to continue to own the covered securities, but without the full risks and rewards of ownership. When that occurs, the director, officer or other associate may no longer have the same objectives as Elevance Health's other shareholders. Therefore, these types of transactions are prohibited by this Policy.

Margin Accounts and Pledging

Section 16 Officers, Directors and Designated Insiders are prohibited from holding Elevance Health Securities in a margin account or pledging Elevance Health Securities as collateral for a loan. A margin sale or foreclosure sale may occur at a time when the pledgor is aware of material nonpublic information or otherwise is not permitted to trade in Elevance Health Securities. Securities held in a margin account may be sold by the broker without the customer's consent if the customer fails to meet a margin call. Similarly, securities pledged (or hypothecated) as collateral for a loan may be sold in foreclosure if the borrower defaults on the loan.

While Elevance Health associates who are not Section 16 Officers, Directors or Designated Insiders are not prohibited from using Elevance Health Securities as collateral for loans or in margin accounts, the Company strongly discourages associates from such activity, and recommends that if Elevance Health Securities are pledged, associates should be sure to retain the financial capacity to repay the loan without resort to the pledged securities.

Post-Termination Transactions

This Policy continues to apply to your transactions in Elevance Health Securities even after you have terminated employment. If you are in possession of material nonpublic information when your employment terminates, you may not trade in Elevance Health Securities until that information has become public or is no longer material.

Rule 10b5-1 Trading Plans

Rule 10b5-1 under the Exchange Act provides a defense from insider trading liability under Rule 10b-5. In order to be eligible to rely on this defense, a person subject to this Policy must enter into a Rule 10b5-1 plan for transactions in Elevance Health Securities that meets certain conditions specified in the Rule (a "Rule 10b5-1 Plan") and must be entered into and approved in accordance with the Company's 10b5-1 Plan Guidelines set forth in Attachment A of in this Policy. If the plan meets the requirements of Rule 10b5-1, transactions in Elevance Health Securities may occur even when the person who has entered into the plan later becomes aware of material nonpublic information.

In general, a Rule 10b5-1 Plan must be entered into at a time when the person entering into the plan is not aware of material nonpublic information. Once the plan is adopted, the person must not exercise any influence over the amount of securities to be traded, the price at which they are to be traded or the date of the trade.

7. Individual Responsibility

You have ethical and legal obligations to maintain the confidentiality of information about the Company and to not engage in transactions in Elevance Health Securities while in possession of material nonpublic information. Persons subject to this Policy must not engage in illegal trading and must avoid the appearance of improper trading. You are responsible for making sure that you comply with this Policy, and that any of your family members, household members or entities whose transactions are subject to this Policy, as discussed above, also comply with this Policy. In all cases,

the responsibility for determining whether you are possession of material nonpublic information rests with you, and any action on the part of the Company, the Company's legal counsel or any other associate pursuant to this Policy (or otherwise) does not in any way constitute legal advice or insulate you from liability under applicable securities laws.

You may obtain additional guidance on this Policy or its application to any proposed transaction from:

Kathy Kiefer	Jamie Burnett
Chief Governance Officer, Corporate Secretary & VP Legal	Managing Associate General Counsel Senior & Assistant Corporate Secretary

Effective Date

(Last amended on 1/31/2025)

Guidelines for Rule 10b5-1 Plans

Rule 10b5-1 under the Exchange Act (the "Rule") provides a defense from insider trading liability. In order to be eligible to rely on this defense, individuals must enter into a securities trading plan that meets the conditions specified in the Rule (a "Rule 10b5-1 Plan").

A Rule 10b5-1 Plan must be entered into at a time when the person entering into the plan is not aware of material nonpublic information. Once the plan is adopted, the person must not exercise any influence over the amount of securities to be traded, the price at which they are to be traded and the date of the trade. The plan must either specify the amount, pricing and timing of securities transactions in advance or delegate discretion on these matters to an independent third party.

The following guidelines apply to Rule 10b5-1 Plans entered into by officers, directors and associates of Elevance Health, Inc. or its subsidiaries for purposes of selling Elevance Health Securities:

- The 10b5-1 Plan must be in writing and signed by the person adopting the trading plan, the broker, and the Company's Corporate Secretary or their designee.
- A Rule 10b5-1 Plan must be in a form approved by the Company's Corporate Secretary and meet the requirements of Rule 10b5-1 and these guidelines.
- Any Rule 10b5-1 Plan should be submitted to the Corporate Secretary for approval five days prior to the entry into the Rule 10b5-1 Plan.
- Individuals party to a Rule 10b5-1 Plan may not enter into or modify the plan while they are aware of material nonpublic information or during a Quarterly Blackout Period (for Designated Insiders) or an Event-Specific Blackout Period to which they are subject.
- For Section 16 Officers and Directors (each as defined in Elevance Health's Insider Trading Policy), no transaction may take place under a Rule 10b5-1 Plan until the later of (a) 90 days after adoption or modification (as specified in Rule 10b5-1) of the Rule 10b5-1 Plan or (b) two business days following the disclosure of the Company's financial results in a Form 10-Q or Form 10-K for the fiscal quarter in which the Rule 10b5-1 Plan was adopted or modified. In any event, the cooling-off period is subject to a maximum of 120 days after adoption of the plan.
- For persons other than Section 16 Officers and Directors, no transaction may take place under a Rule 10b5-1 Plan until 30 days following the adoption or modification of a Rule 10b5-1 Plan.
- Subject to certain limited exceptions specified in Rule 10b5-1, you may not enter into more than one Rule 10b5-1 Plan at the same time.
- Subject to certain limited exceptions specified in Rule 10b5-1, you are limited in any 12-month period to only one Rule 10b5-1 Plan designed to effect an open market purchase or sale of the total amount of securities subject to the Rule 10b-1 Plan as a single transaction in any 12-month period.

- You must act in good faith with respect to a Rule 10b5-1 Plan. A Rule 10b5-1 Plan cannot be entered into as part of a plan or scheme to evade the prohibition of Rule 10b-5. Therefore, although modifications to an existing Rule 10b5-1 Plan are not prohibited, a Rule 10b5-1 Plan should be adopted with the intention that it will not be amended or terminated prior to its expiration.
- Section 16 Officers and Directors must include a representation to the Company at the time of adoption or modification of a Rule 10b5-1 Plan that (i) the person is not aware of material nonpublic information about Elevance Health or Elevance Health's securities and (ii) the person is adopting the plan in good faith and not as part of plan or scheme to evade the prohibitions of Rule 10b-5.
- The Company and the Company's Section 16 Officers and Directors must make certain disclosures in SEC filings concerning Rule 10b5-1 Plans. Section 16 Officers and Directors must undertake to provide any information requested by the Company regarding Rule 10b5-1 Plans for the purpose of providing the required disclosures or any other disclosures that the Company deems to be appropriate under the circumstances.

Each Section 16 Officer and Director understands that the approval or adoption of a pre-planned selling program in no way reduces or eliminates the obligations of the Company's Section 16 Officers and Directors under Section 16 of the Exchange Act, including such person's disclosure and short-swing trading liabilities thereunder. If any questions arise, such person should consult with their own counsel in implementing a Rule 10b5-1 Plan.

Listed below are subsidiaries of Elevance Health, Inc. as of February 1, 2025 with ownership of 50% and above.		
Entity Name	**Domestic Jurisdiction**	**Doing Business As**
4600 Group, LLC	California	4600BOEHM
4600 Group Holdings, LLC	California	
Advantage Medical Group, LLC	Puerto Rico	
Alianza Medicos del SurEste, LLC	Puerto Rico	
Alliance Care Management, LLC	Delaware	
Amerigroup Mississippi, Inc.	Mississippi	
Amerigroup Pennsylvania, Inc.	Pennsylvania	
AMGP Georgia Managed Care Company, Inc.	Georgia	AMERIGROUP; AMERIGROUP Community Care; AMERIGROUP Georgia; AMGP Georgia
AMH Health, LLC	Maine	
AMH Health Plans of Maine, Inc.	Maine	
Anthem Benefits Agency, Inc. f/k/a EHC Benefits Agency, Inc.	New York	
Anthem Blue Cross Life and Health Insurance Company	California	
Anthem Financial, Inc.	Delaware	
Anthem Health Plans, Inc.	Connecticut	Anthem Blue Cross and Blue Shield
Anthem Health Plans of Kentucky, Inc.	Kentucky	Anthem Blue Cross and Blue Shield
Anthem Health Plans of Maine, Inc.	Maine	Anthem Blue Cross and Blue Shield; Associated Hospital Service
Anthem Health Plans of New Hampshire, Inc.	New Hampshire	Anthem Blue Cross and Blue Shield
Anthem Health Plans of Virginia, Inc.	Virginia	Anthem Blue Cross and Blue Shield
Anthem HealthChoice Assurance, Inc., f/k/a Empire HealthChoice Assurance, Inc.	New York	Anthem Blue Cross; Anthem Blue Cross and Blue Shield

Anthem HealthChoice HMO, Inc. f/k/a Empire HealthChoice HMO, Inc.	New York	Anthem Blue Cross, Anthem Blue Cross and Blue Shield
Anthem Holding Corp.	Indiana	Anthem Properties, Inc.
Anthem HP, LLC	New York	Anthem Blue Cross and Blue Shield HP, Anthem Blue Cross HP
Anthem Insurance Companies, Inc.	Indiana	Anthem Blue Cross and Blue Shield Retiree Solutions; Anthem Blue Cross Retiree Solutions; Blue Cross and Blue Shield of Indiana; Anthem Blue Cross and Blue Shield
Anthem Kentucky Managed Care Plan, Inc.	Kentucky	Anthem Blue Cross and Blue Shield Medicaid
Anthem Partnership Holding Company, LLC	Indiana	
Anthem Southeast, Inc.	Indiana	
Appalachian Home Infusion, LLC	Georgia	
APR, LLC	Indiana	
Arcus Enterprises, Inc.	Delaware	
Associated Group, Inc.	Indiana	
ATH Holding Company, LLC	Indiana	
AUMSI UM Services, Inc.	Indiana	
Best Transportation of PR LLC	Puerto Rico	
BioPlus Parent, LLC	Delaware	
BioPlus Specialty Holding Company, LLC	Indiana	
BioPlus Specialty Infusion AL, LLC	Alabama	
BioPlus Specialty Infusion CA, LLC	California	
BioPlus Specialty Infusion Holdings, Inc.	Delaware	
BioPlus Specialty Infusion TX, LLC	Texas	
BioPlus Specialty Pharmacy CA, LLC	Delaware	
BioPlus Specialty Pharmacy FL 2, LLC	Delaware	
BioPlus Specialty Pharmacy Holdings 3, LLC	Delaware	
BioPlus Specialty Pharmacy Holdings I, Inc.	Delaware	

BioPlus Specialty Pharmacy Holdings II, Inc.	Delaware	
BioPlus Specialty Pharmacy Holdings, Inc.	Delaware	
BioPlus Specialty Pharmacy LA, LLC	Louisiana	
BioPlus Specialty Pharmacy Services, LLC	Florida	
BioPlus Specialty Pharmacy, Inc.	Florida	Kroger Specialty Pharmacy FL
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	Georgia	Anthem Blue Cross and Blue Shield
Blue Cross Blue Shield of Wisconsin	Wisconsin	Anthem Blue Cross and Blue Shield
Blue Cross of California	California	Anthem Blue Cross
Blue Cross of California Partnership Plan, Inc.	California	Anthem Blue Cross Partnership Plan
Boehm & Associates, LLC	California	
Capricorn Holdco, Inc. f/k/a Indiana University Health Plans, Inc.	Indiana	
Carebridge Holding Company, LLC	Indiana	
Carelon Behavioral Care, Inc.	Delaware	
Carelon Behavioral Health, Inc.	Virginia	FHC CHOICE
Carelon Behavioral Health IPA, Inc.	New York	
Carelon Behavioral Health of California, Inc.	California	
Carelon Behavioral Health Holdings, Inc.	Virginia	
Carelon Behavioral Health Strategies IPA, LLC	New York	
Carelon Behavioral Health Strategies, LLC	Massachusetts	
Carelon Digital Platforms, Inc.	Indiana	
Carelon Digital Platforms Israel Ltd	Israel	
Carelon Employment Company, LLC	Indiana	
Carelon Global Solutions India LLP	India	
Carelon Global Solutions Ireland Limited	Ireland	
Carelon Global Solutions Philippines, Inc.	Philippines	
Carelon Global Solutions Puerto Rico, L.L.C.	Puerto Rico	
Carelon Global Solutions U.S., Inc.	Indiana	

Carelon Health Federal Services, Inc.	Virginia	
Carelon Health of New Jersey, Inc.	New Jersey	
Carelon Health of Pennsylvania, Inc.	Pennsylvania	
Carelon Health of Texas	Texas	
Carelon Health Solutions, Inc.	Virginia	
Carelon Health, Inc.	Indiana	
Carelon Holdings I, Inc.	Indiana	
Carelon Holdings II, LLC.	Indiana	
Carelon Insights, Inc.	Indiana	Carelon Insights Administrator
Carelon Insights IPA of New York, LLC	New York	
Carelon Medical Benefits Management, Inc.	Illinois	
Carelon Palliative Care, Inc. f/k/a Aspire Health, Inc.	Delaware	
Carelon Research, Inc.	Delaware	
Carelon Subrogation, LLC	Wisconsin	
Carelon, Inc. f/k/a Carelon Holdings, Inc.	Indiana	
CarelonRx, Inc.	Indiana	
CarelonRx Pharmacy, Inc.	Delaware	
Caremax Pharmacy of Loudon, Inc.	Tennessee	
Caribbean Accountable Care, LLC	Puerto Rico	
Castellana Physician Services, LLC	Puerto Rico	
CCHA, LLC	Colorado	Colorado Community Health Alliance
Centers for Specialty Care Group IPA, LLC	New York	Centers Care Solutions IPA
Centers Plan for Healthy Living LLC	New York	
Centros de Medicina Primaria Advantage del Norte, LLC	Puerto Rico	
Centro Medicina Familiar del Norte, LLC	Puerto Rico	
Centros Medicos Unidos del Oeste, LLC	Puerto Rico	
Cerulean Companies, Inc.	Georgia	
Clinica Todo Salud - Aibonito, LLC	Puerto Rico	
Clinica Todo Salud, LLC	Puerto Rico	
Clinical Staff Solutions, LLC	Puerto Rico	
Colorado State Infusion, Inc.	Colorado	
Coltello Pharmaceuticals, LLC	Texas	

Community Care Health Plan of Kansas, Inc.	Kansas	Healthy Blue
Community Care Health Plan of Louisiana, Inc.	Louisiana	Healthy Blue
Community Care Health Plan of Nebraska, Inc.	Nebraska	WellCare of Nebraska; Healthy Blue
Community Care Health Plan of Nevada, Inc.	Nevada	Anthem Blue Cross and Blue Shield Healthcare Solutions;
Community Insurance Company	Ohio	Anthem Blue Cross and Blue Shield
Compcare Health Services Insurance Corporation	Wisconsin	Anthem Blue Cross and Blue Shield
Consorcio MultiSalud del Norte, Inc.	Puerto Rico	
Consorcio MultiSalud del Oeste, Inc.	Puerto Rico	
Crossroads Acquisition Corp.	Delaware	
DeCare Analytics, LLC	Minnesota	
DeCare Dental Health International, LLC	Minnesota	
DeCare Dental Insurance Ireland, Ltd.	Ireland	
DeCare Dental Networks, LLC	Minnesota	
DeCare Dental, LLC	Minnesota	
DeCare Operations Ireland, Limited	Ireland	
Delivery Network, LLC	Florida	
Dental Services Organization, LLC	Puerto Rico	
Designated Agent Company, Inc.	Kentucky	
Dogwood Pharmacy, LLC	Florida	Medscripts Medical Pharmacy, LLC
EasyScripts Cutler Bay, LLC	Florida	EasyScripts, LLC
EasyScripts Hialeah, LLC	Florida	EasyScripts, LLC
EasyScripts Westchester, LLC	Florida	EasyScripts, LLC
EasyScripts, LLC	Florida	EasyScripts Cutler Bay, LLC; EasyScripts Hialeah, LLC; EasyScripts Westchester, LLC
ELV Holding Company 2, LLC	Indiana	
ELV Holding Company 3, LLC	Indiana	
ELV Holding Company 4, LLC	Indiana	
ELV Holding Company, LLC	Indiana	

Elevance Health Information Technology Services, Inc. f/k/a WellPoint Information Technology Services, Inc.	California	
Farmacia Doral, Inc.	Puerto Rico	
Federal Government Solutions, LLC	Wisconsin	
Freedom Health, Inc.	Florida	
Freedom SPV, Inc.	Delaware	
Golden West Health Plan, Inc.	California	
GR Health Solutions, LLC	Pennsylvania	
Group Retiree Health Solutions, Inc.	Pennsylvania	Blue Medicare Advantage
Grupo Advantage del Oeste, LLC	Puerto Rico	
Grupo Advantage Metro, LLC	Puerto Rico	
HaloCare Specialty Therapeutics, LLC	Louisiana	
Healthcare Subrogation Group, L.L.C.	Delaware	
Health Ventures Partner, L.L.C.	Illinois	
HealthKeepers, Inc.	Virginia	
HealthLink Administrators, Inc.	Missouri	
HealthLink, Inc.	Illinois	
HealthSun Health Plans, Inc.	Florida	
HealthSun Physicians Network I, LLC	Florida	
HealthSun Physicians Network, LLC	Florida	
Healthy Alliance Life Insurance Company	Missouri	Anthem Blue Cross and Blue Shield
Highland Acquisition Holdings, LLC	Delaware	
Highland Intermediate Holdings, LLC	Delaware	
Highland Investor Holdings, LLC	Delaware	
HMO Colorado, Inc.	Colorado	HMO Colorado; HMO Nevada
HMO Missouri, Inc.	Missouri	Amerigroup Missouri; Anthem Blue Cross and Blue Shield
IEC Group Holdings, Inc.	Idaho	
IEC Group, Inc.	Idaho	AmeriBen
InHealth Management, LLC	Puerto Rico	
Innovative Infusions, L.L.C.	Texas	Paragon Infusion Centers
Innovative Pharmacy Services, LLC	Delaware	
InSite Therapy Centers, LLC	Texas	
IPA Holdings, LLC	Puerto Rico	
LDNR Pharmacy, Inc.	California	
Living Complete Technologies, Inc.	Maryland	

MAPR Capital, LLC	Puerto Rico	
MAPR Global, LLC	Puerto Rico	
MAPR Holdings, LLC	Puerto Rico	
Massachusetts Behavioral Health Partnership	Massachusetts	
Matthew Thornton Health Plan, Inc.	New Hampshire	
Medical Dental Network Management, LLC	Puerto Rico	
Medway Infusion Services, LLC	Texas	
Missouri Care, Incorporated	Missouri	Healthy Blue
MMM Healthcare, LLC	Puerto Rico	
MMM Holdings, LLC	Puerto Rico	
MMM Multi Health, LLC	Puerto Rico	
MMM Transportation, LLC	Puerto Rico	
Momentum Health Partners, LLC	North Carolina	
MSO Holdings, LLC	Puerto Rico	
MSO of Puerto Rico, LLC	Puerto Rico	
Nash Holding Company, LLC	Delaware	
National Government Services, Inc.	Indiana	NGS of Indiana
New England Research Institutes, Inc.	Massachusetts	
NGS Federal, LLC	Indiana	
Optimum Healthcare, Inc.	Florida	
OPTIONS Health Care, Inc.	Delaware	
Paragon Healthcare, Inc.	Texas	
Paragon Hemophilia Solutions, LLC	Texas	Paragon Healthcare Specialty, LLC
Paragon Holding Company, LLC	Indiana	
Paragon Infusion Care, Inc.	Texas	
Paragon Nutrition Care, LLC	Texas	
Pasteur Medical Bird Road, LLC	Florida	Pasteur Medical Center, LLC
Pasteur Medical Center, LLC	Delaware	
Pasteur Medical Cutler Bay, LLC	Florida	Pasteur Medical Center, LLC
Pasteur Medical Group, LLC	Florida	Pasteur Medical Center, LLC
Pasteur Medical Hialeah Gardens, LLC	Florida	Pasteur Medical Center, LLC
Pasteur Medical Kendall, LLC	Florida	Pasteur Medical Center, LLC

Pasteur Medical Management, LLC	Florida	Pasteur Medical Bird Road, LLC; Pasteur Medical Center, LLC; Pasteur Medical Cutler Bay, LLC; Pasteur Medical Group, LLC; Pasteur Medical Hialeah Gardens, LLC; Pasteur Medical Kendall, LLC; Pasteur Medical Miami Gardens, LLC; Pasteur Medical North Miami Beach, LLC; Pasteur Medical Partners, LLC
Pasteur Medical Miami Gardens, LLC	Florida	Pasteur Medical Center, LLC
Pasteur Medical North Miami Beach, LLC	Florida	Pasteur Medical Center, LLC
Pasteur Medical Partners, LLC	Florida	Pasteur Medical Center, LLC
PathWrite, Inc.	Texas	Paragon Infusion Services, Inc.
PHI Parent LLC	Delaware	
PHM Healthcare Solutions, Inc.	Puerto Rico	
PHM IntraHospital Physician Group, LLC	Puerto Rico	
PHM MultiDisciplinary Clinic Aguadilla LLC	Puerto Rico	
PHM MultiDisciplinary Clinic Arecibo LLC	Puerto Rico	
PHM MultiDisciplinary Clinic Cabo Rojo LLC	Puerto Rico	
PHM MultiDisciplinary Clinic Guayama LLC	Puerto Rico	
PHM MultiDisciplinary Clinic Maunabo LLC	Puerto Rico	
PHM MultiDisciplinary Clinic, LLC	Puerto Rico	
PHM MultiSalud, LLC	Puerto Rico	
PHM Specialty Network, LLC	Puerto Rico	
Physician Group Practices, LLC	Puerto Rico	
PMC Medicare Choice, LLC	Puerto Rico	
Raina RX LLC	New York	Route 300 Pharmacy in NY

RightCHOICE Managed Care, Inc.	Delaware	RightCHOICE Benefit Administrators; Anthem Blue Cross and Blue Shield
River Medical Pharmacy, LLC	Florida	
Rocky Mountain Hospital and Medical Service, Inc.	Colorado	Anthem Blue Cross and Blue Shield; Anthem Blue Cross Blue Shield
RSV QOZB LTSS, Inc.	Delaware	
Santa Barbara Specialty Pharmacy, LLC	California	
SellCore, Inc.	Delaware	SellCore Insurance Services, Inc.
Simply Healthcare Plans, Inc.	Florida	Clear Health Alliance; Better Health; Amerigroup Florida
Southeast Services, Inc.	Virginia	
State Sponsored Services, Inc.	Indiana	Amerigroup GBD Behavioral Health; Anthem GBD Behavioral Health
The Elevance Health Companies of California, Inc.	California	
The Elevance Health Companies of Puerto Rico, LLC	Puerto Rico	
The Elevance Health Companies, Inc.	Indiana	
VITA Care, LLC	Puerto Rico	Anthem Benefit Services; The Anthem Companies Indiana
Wellmax Health Medical Centers, LLC	Florida	Wellmax Medical Center
Wellmax Health Physicians Network, LLC	Florida	
WellPoint Acquisition, LLC	Indiana	
WellPoint California Services, Inc.	Delaware	
Wellpoint Corporation	Delaware	Wellpoint Insurance Services; Wellpoint Insurance Services Corporation
Wellpoint Delaware, Inc.	Delaware	
WellPoint Dental Services, Inc.	Delaware	
Wellpoint District of Columbia, Inc. f/k/a Amerigroup District of Columbia, Inc.	District of Columbia	

Wellpoint Federal Corporation	Indiana	
WellPoint Health Solutions, Inc.	Indiana	
WellPoint Holding Corp.	Delaware	
Wellpoint Illinois Services, Inc. f/k/a UNICARE Illinois Services, Inc.	Illinois	
Wellpoint Insurance Company	Texas	
Wellpoint Insurance Services, Inc.	Hawaii	
Wellpoint Iowa, Inc.	Iowa	
Wellpoint IPA of NY, LLC	New York	
Wellpoint Life and Health Insurance Company	Indiana	Simply Healthcare
Wellpoint Maryland, Inc.	Maryland	
Wellpoint National Services, Inc. f/k/a UNICARE National Services, Inc.	Delaware	
Wellpoint New Jersey, Inc.	New Jersey	
Wellpoint New Mexico, Inc. f/k/a AMERIGROUP Community Care of New Mexico, Inc.	New Mexico	
Wellpoint Ohio, Inc.	Ohio	
Wellpoint Partnership Plan, LLC	Illinois	
Wellpoint South Carolina, Inc.	South Carolina	
Wellpoint Specialty Services, Inc. f/k/a UNICARE Specialty Services, Inc.	Delaware	
Wellpoint Tennessee, Inc. .	Tennessee	
Wellpoint Texas, Inc.	Texas	
Wellpoint Washington, Inc.	Washington	
Wellpoint West Virginia, Inc. f/k/a UNICARE Health Plan of West Virginia, Inc.	West Virginia	
Westcare, Inc.	Colorado	
XCEL Reimbursement Solutions, LLC	Texas	

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

- Form S-8 No. 333-84906 and Form S-8 No. 333-129334 pertaining to the Elevance Health 401(k) Plan;
- Form S-8 No. 333-156099 pertaining to the Elevance Health Employee Stock Purchase Plan;
- Form S-8 No. 333-159830 pertaining to the Elevance Health Incentive Compensation Plan;
- Form S-8 No. 333-218190 pertaining to the 2017 Elevance Health Incentive Compensation Plan; and
- Form S-3 No. 333-275251 pertaining to the Elevance Health, Inc. registration of senior debt securities, subordinated debt securities, preferred stock, common stock, depositary shares, warrants, rights, stock purchase contracts and stock purchase units

of our reports dated February 20, 2025, with respect to the consolidated financial statements and financial statement schedule listed in the Index at Item 15(c) of Elevance Health, Inc. and the effectiveness of internal control over financial reporting of Elevance Health, Inc. included in this Annual Report (Form 10-K) of Elevance Health, Inc. for the year ended December 31, 2024.

/s/ Ernst & Young LLP

Indianapolis, Indiana
February 20, 2025

Exhibit 31.1

CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Gail K. Boudreaux, certify that:

1. I have reviewed this report on Form 10-K of Elevance Health, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c. evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a. all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2025

/s/ GAIL K. BOUDREAUX
President and Chief Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Mark B. Kaye, certify that:

1. I have reviewed this report on Form 10-K of Elevance Health, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c. evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):

   a. all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2025

/s/ MARK B. KAYE

Executive Vice President and
Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Elevance Health, Inc. (the "Company") on Form 10-K for the period ended December 31, 2024 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Gail K. Boudreaux, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ GAIL K. BOUDREAUX

Gail K. Boudreaux
President and Chief Executive Officer
February 20, 2025

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Elevance Health, Inc. (the "Company") on Form 10-K for the period ended December 31, 2024 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Mark B. Kaye, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ MARK B. KAYE

Mark B. Kaye
Executive Vice President and Chief Financial Officer
February 20, 2025