Transparency in Coverage Regulation and Consolidated Appropriations Act

External FAQs for Fully Insured and ASO including Anthem Balanced Funding (ABF)

NOTE: For JAA/MCS clients, please refer to the JAA/MCS FAQ document.

Last Update: February 2024 (gray highlight indicates updates)

The information in this document does not constitute legal advice. Customers should consult their legal team for further questions or advice.*

Transparency in Coverage – Final Regulation

General

Anthem supports meaningful transparency efforts that help consumers make informed health care decisions. In August 2021, the Department of Labor, in conjunction with the Departments of Health and Human Services (HHS) and the Treasury, (known collectively as the "Tri-Agencies") issued updated guidance related to implementation of the Consolidated Appropriations Act (CAA) and Transparency in Coverage (TIC) final rule. The guidance delayed enforcement and provided good faith compliance safe harbors related to the implementation of a number of provisions of the CAA and TIC.

The TIC regulation (Regulation) requires health insurers and group health plans (Health Plans) to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered healthcare items and services, Health Plan expanded those tools to cover all items and services by January 1, 2024. CMS has indicated it will issue additional guidance on this provision and how it relates to the CAA price comparison requirements. The rule also required Health Plans to make public machine-readable files (MRF) beginning on July 1, 2022 (delayed from January 1, 2022) that contain the negotiated rates with in-network providers for all covered items and services as well as historical payments to and billed charges from out-of-network providers. The requirement to post an MRF containing the in-network negotiated rates and historical net prices for all covered prescription drugs by a plan or issuer at the pharmacy location is pending technical requirements and an implementation timeline, which the Tri-Agencies will provide in future guidance. The purpose of the rule is to provide transparency that federal regulators believe will promote consumer choice and competition among providers. In instances where rates cannot be disclosed in specified amounts (e.g., dollar), the Tri-Agencies will use a case-by-case approach to determine whether enforcement is appropriate.

Anthem is not amending its fully insured contract to reflect these laws, since there is a standard provision stating Anthem will comply with applicable law. Anthem will be updating Certificates of Coverage as needed, depending on state law, to inform members of their benefits under these laws.

Anthem is amending the ASO agreement as described at the end of this FAQ to incorporate the services Anthem will be providing under the Regulation and CAA.

What areas will Anthem take responsibility for and make updates to be in compliance?
Anthem developed an implementation strategy for achieving the Transparency requirements, the intent of which is to provide a compliant solution which applies equally to fully insured and self-funded (ASO) clients for the data we administer and maintain.

How will carve-out situations be handled?
In situations where a group has a vendor other than Anthem for certain services (e.g., Pharmacy), Anthem's pricing and rate information will not apply to the services supplied by the third-party vendor.

Will Anthem be amending par-provider contracts to allow for the disclosure of rates for the purpose of satisfying the transparency requirements?
Anthem's participating provider contracts permit the disclosure of proprietary information where required by law or regulation, but only as it relates to the scope of the specific mandate and not beyond what is required by law.

What areas does Anthem feel are already in compliance with no change needed? Where are the current tools relative to the requirements as they are outlined by effective dates?
While Anthem does have member transparency tools, such as Find Care in place and currently available for much of our business, changes will be required based on the current language in the Regulation.

Will there be a cost for hosting the platforms or providing the data?
There will be no additional charge for this specifically. However, the new regulations will be taken into consideration when determining our administrative fees.

Will you support the employer's communication to their employees on these changes and new resources?
We do anticipate communicating with employers as to our implementation activities for these laws. Employers may use these communications to develop communications for their employees.

List any subcontractors or third parties who are providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan.
Anthem does not plan to use subcontractors for the machine-readable file. Use of subcontractors for other services will be determined once regulations are issued.

What plans are subject to the Transparency Rule?
According to the Regulation, the Transparency Rule applies to health insurance issuers in the group and individual markets. It also applies to group health plans, including group health plans that are fully insured, as well as those that are self-funded. It also applies to Qualified Health Plan issuers and the Federal Employees Health Benefits Program. The Rule does not, however, apply to Medicare Advantage, Medicare Supplement, Medicaid MCO coverage, or vision or dental only plans. Nor does the Transparency Rule apply to grandfathered health plans or to short term, limited duration insurance.

Machine-Readable Files

What is a machine-readable file?
A machine-readable file is defined as a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost. The final rules require each machine-readable file to use a non-proprietary, open format. The machine-readable files for the data we administer and maintain will be made accessible through anthembluecross.com. Employers can link to those files; but due to the size of the files, we will not be providing the data directly to our clients for them to put on their websites. Anthem will only be publishing the data it maintains, so if a plan uses a third-party vendor, such as a PBM, then the group should work with that vendor to determine whether it is providing a similar solution.

What are machine-readable files intended to be used for?
According to the preamble to the Transparency in Coverage rule, the purpose of the files is to allow "the public to have access to health coverage information that can be used to understand health care pricing and potentially dampen the rise in health care spending." The government expects private entities to create apps or websites to enable consumers to view and compare this rate information. Once again, the files are "machine readable," so consumers must rely on someone with a computer program and system capability to digest the files and render them viewable.

Members can log in to anthembluecross.com and use our cost transparency tools such as Find Care and Virtual Care to shop for health services and understand how costs differ from provider to provider.

How often will the machine-readable files be updated?
The files will be updated monthly on the first of each month.

Will you create these files and/or the website internally or utilize a subcontractor? If you are using a subcontractor, will you offshore?
We create these files internally.

Will you only provide your data, or will your platform allow for merging other vendor's data (e.g., PBM, specialty network, etc.)?
We only provide the data we administer and maintain.

Will the publicly available files be accessed through the current participant portal or be located in a new portal? Will you provide the files to plan sponsors or can plan sponsors link to the files?
These files are accessible through anthembluecross.com on a publicly available website. Due to the size of the files, we will not provide the data directly to our clients. Plan sponsors may link to those files as desired.

How will you monitor and validate your processes to ensure the ongoing accuracy of the data in the files?
Quality Audit (QA) processes are an integral part of our monthly file postings. Validation occurs at all points in the process including ensuring the source data from the multiple systems is being pulled in correctly, validating results of the data from the source system pull, and validation of data as it appears in production.

How will client-specific machine readable files be accessed on anthembluecross.com?

Beginning July 1, 2022, and on the first of every month thereafter, Anthem will publish the machine-readable files for the plans we administer and maintain on anthembluecross.com using this link: https://www.anthembluecross.com/machine-readable-file/search. This link can be added to the group health plan's public website to fulfill the group health plan posting requirement. This link will allow you to search for your files using your Employer Identification Number (EIN).

What is an Employer Identification Number (EIN)?

An Employer Identification Number (EIN) is a unique nine-digit identification code issued by the Internal Revenue Service (IRS) to a business. The CMS file layout requires group rate information to be loaded using the group EIN.

May a group health plan that does not have its own website satisfy the requirements of the TIC Final Rules with respect to posting the Allowed Amount file and the In-network Rate file on a public website of the plan, if the plan's service provider posts the Allowed Amount file and the In-network rate file on its public website on behalf of the group health plan?

Per CMS FAQ #37 published on 6/17/22 (https://www.cms.gov/healthplan-price-transparency/resources/technical-clarification), if a group health plan does not have a public website, the plan may satisfy the requirements for posting the Allowed Amount file and the In-Network file by entering into a written agreement under which a service provider (such as a TPA) posts the Allowed Amount file and the In-network Rate file on its public website on behalf of the plan. However, if a plan enters into an agreement under which a service provider agrees to post the Allowed Amount file and the In-network Rate file on its public website on behalf of the plan, and the service provider fails to do so, the plan violates these disclosure requirements. The Departments intend to follow up with the issuance of formal guidance soon**.**

How do I know which file to pick for my product?

The JSON File naming convention will reflect the product name (e.g., PPO, HMO).

Please describe how your organization will respond to questions regarding the files.

Please contact your Account Manager for any specific questions regarding the files. Your Account Manager will ensure that the question is routed to the appropriate team for response.

Will you provide the plan with any of the three machine-readable files on a monthly basis including in-network rates, out-of-network allowed amounts, and prescription drug negotiated rates (for drugs dispensed under the medical plan)?

No, due to their size, the machine-readable files will only be made available on anthembluecross.com.

How do you handle rates for providers that have been terminated?

Terminated providers will be dropped each month and new provider records will be added. Changes will be reflected in the files the month after the termination.

Will the machine-readable files be archived and how will the archived files be accessed?

The files will be archived according to the legal retention period of 10 years. If a regulator requests information associated with a file, please reach out to us and we will work with the regulator to get the information they need. The client also has the ability to download and archive.

Cost Transparency Tool

The Transparency in Coverage regulation (Regulation) requires health insurers and group health plans (Health Plans) to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered health care items and services, health plans expanded those tools to cover all items and services effective January 1, 2024.

The CAA also requires plans to make available to members a price comparison tool to enable a member to compare the amount of cost-sharing the individual would be responsible for paying under the plan with respect to a specific item or service by a participating provider.

How will Anthem make the tool available to plan participants? Through your website, by providing information to plans, or through another option?
The tool is available through our website. Data produced from the tool will be based on information Anthem administers and maintains.

How will you respond to individuals who request the information on paper or by telephone instead of through the website?
Requests for information on paper or by telephone will be handled by Member Services.

Consolidated Appropriations Act (CAA) - Law pending final regulations

General

The CAA represents the most significant changes to the private insurance market since the Affordable Care Act (ACA). The law:

- Requires plans to develop and make available price transparency tools, good faith estimates and an advanced explanation of benefits
- Restricts “surprise billing”
- Prohibits “gag clauses” in healthcare contracts
- Adds new mandates for ID cards, provider directories and continuity ofcare.

These provisions are described in more detail below but note that much of the important detail of this law will be determined by regulations that will be released in future rulemaking.

Anthem is working alongside other stakeholders to assess the operational complexities and timelines for implementation and continues to make recommendations to the Tri-Agencies who must develop these regulations.

Who does this law apply to?
All types of employer plans, including self-funded employers as well as health insurance issuers in the individual and group markets.

What types of plans are excluded from the scope of the CAA?

- Short-Term Limited Duration plans
- Government Plans (e.g. Medicare, Medicaid)
- Retiree Only Plans
- Account Based Plans (e.g. HRA, HSA) *Note: The underlying health plan (e.g. High Deductible Health Plan (HDHP) is in the scope of the CAA.*
- Excepted Benefits (e.g. Standalone Dental or Vision)

What is the effective date of the law?
The CAA included numerous provisions, the majority of which became effective January 1, 2022.

The requirement for plans to provide a good faith estimate of charges and an Advance Explanation of Benefits (AEOB) when notified of a scheduled service by a provider are delayed, pending future regulatory guidance, with no final date set.

The Tri-Agencies also announced they would issue regulations to implement the ID card, provider directory, gag clauses on price and quality data, and continuity of care requirements, but would not do so prior to January 1, 2022. Plans are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date.

Do the CAA and Transparency requirements have any pricing impact to premium/administrative services fees?
At this time, we do not anticipate a direct cost to the client for standard compliance with this provision, except for the surprise bill/IDR process described below for our ASO clients, however the new regulations and laws will be taken into consideration when determining our administrative fees or premium rates we charge our clients.

How will Anthem make additional quality data available to supplement/complement the requirements – and how/when will changes occur going forward?
QA processes are an integral part of our solution designs.

Will you support the employer's communication to their employees on these changes and new resources?
We do anticipate communicating with employers as to our implementation activities for these laws. Employers may use these communications to develop communications for their employees.

List any subcontractors or third parties who are providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan.
Anthem does not plan to use subcontractors for the machine-readable file. Use of subcontractors for other services will be determined once regulations are finalized.

CAA Price Comparison Tool

The CAA requires Health Plans to make available to members a price comparison tool to enable a member to compare the amount of cost-sharing the individual would be responsible for paying under the plan with respect to a specific item or service by a participating provider.

The intent is to align the requirements of the Transparency in Pricing regulation with the Price

Comparison tool requirements of the CAA. Additional rulemaking guidance is anticipated.

Provider Directory

The CAA requires Health Plans to establish a verification process to confirm provider directory information at least every 90 days and establish a procedure to remove providers or facilities who are non-responsive. Health Plans must also develop a response protocol to respond to member network questions. Members who receive inaccurate information that a provider is in-network can only be liable for in-network cost-sharing.

On August 20, 2021, the Tri-Agencies announced they will issue regulations to implement the provider directory requirements but would not do so prior to January 1, 2022. These regulations or other regulatory guidance has not yet been issued. However, Health Plans are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date with a primary focus on ensuring members who rely on provider directory information that inaccurately depicts a provider's network status are only liable for in-network cost sharing amounts. Anthem is moving forward with a focus on good faith compliance while awaiting additional regulatory guidance.

Will a provider directory be available and kept up to date?
Yes.

Will directory be available electronically and/or printed?
Yes.

For your ASO clients, will you accept responsibility for directory inaccuracies resulting in added plan cost?
The Administrative Services Agreement's indemnification provision will apply.

Will you comply with the provider directory requirements on behalf of your employer clients?
Yes, however, much of the important detail of CAA provisions will be determined by future regulatory guidance.

How often will you update the directory?
Those processes will be determined as a part of our design based on implementation guidance from the final regulations.

Will you notify employers of the update?
No.

Will the versions be dated, so employers will know the updates are current?
Those processes will be determined as a part of our design based on implementation guidance from the final regulations.

How will access to the directory be provided (i.e., directly or via an employer website)?
The provider directory is/will be available through our website.

Mental Health Parity

What do the Strengthening Parity in Mental Health (MH) and Substance Use Disorders (SUD) provisions do?

Included as part of the CAA were several measures intended to strengthen parity in MH/SUD benefits, specifically with Non-Quantitative Treatment Limitations (NQTLs). Importantly, if a group health plan that provides both Medical/Surgical (MS) benefits and MH/SUD benefits and imposes NQTLs on MH/SUD benefits, the plan has to perform testing and make testing results available to the Tri-Agencies, or any state authority, upon request within 45 days of enactment of the CAA (generally, no later than February 10, 2021). Plans must also document and make available the following information:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and MS benefits to which each such term applies in each respective benefits classification.
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and MS benefits.
3. The evidentiary standards used for the factors identified in 2 above when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and MS benefits.
4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MS benefits in the benefits classification.
5. The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described above that indicate that the plan or coverage is or is not in compliance.

The Mental Health Parity and Addiction Equity Act (MHPAEA) currently requires NQTL testing, but the CAA creates more formal analyses and reporting. The DOL can begin requesting a comparative analysis report from group health plans beginning on February 10, 2021. The DOL will be issuing regulations on these new requirements.

What is a Non-Quantitative Treatment Limitation (NQTL)?

Mental Health Parity law looks at two types of treatment limitations – quantitative and non-quantitative. Quantitative treatment limitations are the limits that apply to the coverage in the benefit booklets, such as cost-sharing and visit limits. Non-quantitative treatment limitations are behind-the-scenes administrative activities that take place but may impact coverage. Examples include credentialing, how Health Plans determine the amounts to pay providers, utilization management, creation of medical policies and case management. The law requires that Health Plans treat behavioral health conditions no less favorably than we do medical conditions.

Who does this law apply to?

The law applies to all types of group plans, including self-funded employers, as well as health insurance issuers in the individual and group markets. The only commercial products that are not affected are small group grandmothered and grandfathered plans. It does not apply to most

Medicare plans or retiree-only group plans.

How will Anthem comply with this law?
Anthem has created NQTL analysis for its standard processes and procedures (e.g., Credentialing, Case Management, Utilization Review, etc.), which are available free of charge upon request.

Are you able to conduct and provide a detailed written comparative analysis of the design and application of the Non-Quantitative Treatment Limitations (NQTLs) as contemplated by the Consolidated Appropriations Act?
Yes, for the services for which Anthem utilizes its standard policies and procedures. Anthem has used the DOL self-compliance tool to analyze its compliance with the NQTL requirements.

Does the Anthem NQTL analysis apply to all plans subject to the law, whether fully insured or self-insured grouped?
The NQTL analysis applies to all fully insured business. To the extent a self-funded group utilizes Anthem's standard processes and procedures for the administration of its Health Plan (e.g., credentialing), Anthem's NQTL summaries will be applicable to any inquiries. However, if a group deviates from Anthem's standard procedures (e.g., modifies the prior authorization list) or doesn't use Anthem as a vendor for all of its plan administration (e.g., Pharmacy), then NQTL analysis would be the responsibility of the group or its other vendor(s).

Will Anthem provide required documentation for ASO clients?
Anthem will provide our NQTL analysis upon request, which reflects our standard processes and procedures. This NQTL analysis can be provided to groups, members, regulators or providers. It will be updated periodically. However, Anthem will not provide any analysis for NQTLs that are within the group's responsibility (e.g., benefit exclusions, Pharmacy with a non-Anthem vendor, etc.).

Will Anthem perform the NQTL test for ASO groups?
If a group uses our standard policies and procedures, our existing NQTL analysis will apply to them and no group-specific testing is needed. For other NQTLs that are solely within the group's control (e.g., benefit design) or a requested deviation from our standard process (e.g., change to preauthorization listing), the group would be responsible for the NQTL analysis because they know why they made that determination. Also, if a group uses a vendor other than Anthem for an applicable NQTL, such as carved out pharmacy services, then the group will need to work with that vendor for any NQTL analysis.

What action is Anthem taking from the recent proposed rule on Mental Health Parity?
On July 25, 2023, the U.S. Departments of Health and Human Services (HHS), Labor (DOL), and Treasury (together, the Tri-Agencies) released new proposed rules that if adopted would alter the standards plans and issuers must meet to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Anthem will be meeting with internal subject matter experts to assess the proposed changes and consider perspectives from trade associations and employer clients as we prepare to develop feedback.

Please keep in mind the guidance is a proposal, and the proposed effective date of January 2025 is subject to change. Current regulations remain in place, and Anthem continues to operate to demonstrate compliance in accordance with these requirements.

Regardless of the proposal and its impact, Anthem recognizes the importance of mental health and substance abuse services and remain committed to ensuring our clients and members have access to such services and care.

Advance Explanation of Benefits (AEOB)

The CAA requires health plans to provide an advance explanation of benefits (AEOB) for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the network status of those providers, good faith estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums, as well as whether a service is subject to medical management and relevant disclaimers of estimates.

On August 20, 2021, the Tri-Agencies announced an indefinite delay in enforcement of the AEOB requirements. No new enforcement date was set.

Surprise Medical Billing

The CAA includes the "No Surprises Act" which mandates that patients are only responsible for in-network cost-sharing amounts, including deductibles, in emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider (including air ambulance providers). The law also prohibits providers from balance billing except in limited circumstances with patient notice and consent. The act also requires an independent dispute resolution process for providers and plans who cannot reach an agreement on payment.

Much of the important detail of these provisions will be determined by regulations that are still to be released and may be impacted by various court cases. The information provided below incorporates the regulations that were issued on July 1, 2021, and September 30, 2021. On August 19, 2022, the Tri-Agencies issued "Requirements for Surprise Billing: Final Rules." We are expecting another final rule on this provision. The Tri-Agencies have also indicated enforcement discretion until May 1, 2024, for good faith, reasonable interpretation recalculations of the Qualifying Payment Amount ("QPA") to occur. They will continue to evaluate extension of the QPA safe harbor as appropriate.

What is the Qualifying Payment Amount (QPA)?
The QPA is the lesser of the median contracted rate in the metropolitan service area (MSA) for same or similar services and a same or similar provider or billed charge.

Will Anthem determine the Qualifying Payment Amount?
Yes, Anthem will determine the QPA.

How will Anthem define and evaluate service codes for purposes of determining the QPA?
Anthem will use the definitions outlined in the IFR. Service code means the code that describes an item or service, including a Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) Code. Given the requirement that a separate QPA be established for each Service Code, Revenue Codes may also be considered Service Codes under the

outpatient methodology. Based on a Final Rule published in August 2022, Anthem is aligning with the calculation of separate median contracted rates by provider specialty both in instances where its contracting process sets different rates for specialties and where the contracting process results in different rates for different specialties.

How will member cost sharing be determined for use of out-of-network providers/facilities when surprise billing criteria is met?
Anthem will use the QPA to determine the member cost share. Member cost share will be based on the lower of the QPA or provider billed charge.

Does the No Surprises Act apply to ground ambulance as well as air ambulance?
No, the law applies only to air ambulance.

The CAA will require health plans to reimburse out-of-network (OON) providers and facilities in the situations where balance billing is prohibited. Will Anthem be offering services to support this?
Yes, Anthem is prepared to pay the provider directly where applicable.

Are there any state laws that affect your determination of the recognized amount? If so, please describe.
State surprise billing laws will continue to apply to the state's fully insured business and in situations where ASO groups have opted-in to the state law. The Federal "No Surprises Act" will apply to self-funded business and fully insured business in states where there are no surprise billing laws.

How will negotiation and arbitration be handled?
We will negotiate with OON providers for our ASO and fully insured clients. However, an ASO group will be charged any fees related to IDR arbitration. This chargeback is not applicable to fully insured clients.

Will your organization handle arbitrations with out-of-network providers that do not accept the plan's out-of-network rate?
Yes, however for ASO clients, there will be a chargeback to the client for the IDR fees. This chargeback is not applicable to fully insured clients.

Do you have a list of certified IDR entities?
The list of certified IDR entities is available at https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list

What can the client expect in regard to IDR fees and expenses?
CMS issued the following guidance on the ranges of fees that can be expected for Independent Dispute Resolution for calendar years 2023 and 2024:

Fee Type	Applies[i] for disputes initiated between: 1/1/23- 8/2/23	Applies[ii] or disputes initiated between: 8/3/23-1/21/24	Applies[iii] or disputes initiated on or after 1/22/24
Administrative fee	**$350**	**$50**	**$115**
IDRE Fee	Single dispute: **$200-$700** Batched dispute: **$268-$298**	Single dispute: **$200-$700** Batched dispute: **$268-$298**	Single dispute: **$200-$840** Batched dispute: **$268-$1,173**
IDRE Fee Tier Batching - based on the number of line items	2-20 lines: 100%* 21-50 lines: 110% 51-80 lines: 120% >80 lines: 130%	2-20 lines: 100%* 21-50 lines: 110% 51-80 lines: 120% >80 lines: 130%	Fixed fee range: **$75-$250**, *starting with the 26th line item*

**The percentage applies to the approved batched determination fee and increases with the amount of line items included per batch.*

[i] IDR Administrative Fee Guidance 2023 FAQs
[ii] October 2022 Fee Guidance Calendar Year 2023
[iii] IDR Process Fees Final Rule (12/21/23)

Will the IDR Fee be charged to the ASO client under the claims account or as a direct charge to the client?
The IDR Fee will be direct billed.

If the IDR Fee is billed up front and the plan sponsor is determined to be the prevailing party, would the fee be refunded to the ASO client?
The administrative IDR fee is not refundable. It is a charge by the Federal Government to use the Federal website and process. The Arbitrator Fee or CIDRE Fee will only be charged to the client if the provider prevails in arbitration or if the dispute is settled before the arbitrator's decision.

How will these fees show on the ASO client invoice?
They will be in the summary section and broken down in the detail section as well.

What type of reporting on IDR cases will be available to ASO clients?
We will provide both a summary and per member detail of Administrative and Arbitrator fees on the monthly bill when they occur. We are considering other types of reporting in the future and welcome our clients' input on what information would be valuable.

Is there a defined timeline for the Negotiation and IDR Process?
Yes, CMS defines a specified timeline for the negotiations and IDR process including a 30-business day open negotiation period prior to IDR. See the link below for details on the timeline:
https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period

Will you post the required disclosure notice on your website and include it on Surprise Bill member Explanation of Benefits (EOBs) beginning 1/1/22?
Yes. We posted a notice to our site that will meet the mandated requirements and will also be included with applicable Explanation of Benefits (EOBs) beginning 1/1/22. The client can choose to link to our notice. In regard to an ASO client, each entity is responsible for posting on their site as they deem appropriate.

Where on the public site will the model notice be placed?
The notices have been posted at the following website: www.anthembluecross.com/no-surprise-billing

ID Card Requirements

The CAA requires health plans to provide information on ID cards in a clear and understandable manner regarding the amount of the in-network and out-of-network deductibles, the in-network and out-of- network out-of-pocket maximum limitations, and a telephone number and Internet website address through which individuals may seek consumer assistance information.

On August 20, 2021, the Tri-Agencies announced they will issue regulations to implement the ID card requirements but would not do so prior to January 1, 2022. These regulations or other regulatory guidance has not yet been issued. However, Plans and issuers are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date. The Tri-Agencies advised they were aware of the challenges for the plans with complex benefit structures, and provided elements to determine compliance, including the usage of a website where information was not included on the face of the ID card.

Will ID cards be able to include INN/OON deductibles and OOP limits?
Anthem added verbiage to member ID cards advising the member where they can retrieve helpful, easy to understand information regarding their benefits. This information will include up to date in- and out-of-network deductibles and out-of-pocket maximums.

Will ID cards be able to include provider directory contact info?
ID cards currently include a telephone number and Internet website address through which an individual may seek consumer assistance information, such as information related to providers that are participating in their network.

When do you need renewal decisions in order to produce new cards in a timely fashion?
Anthem will make the required changes to any impacted ID cards that we issue with effective dates from January 1, 2022, and forward. ID cards will continue to be issued when required (e.g., any changes necessitating reissuance). For any needed reissuance for plan years on or after January 1, 2022, the changes were be incorporated in our administrative fees.

Given the new guidelines to display in-network (INN) and out-of-network (OON) cost-sharing requirements, we presume the new ID cards need to be issued. Please confirm Anthem's ability to support this and expected timing.
Anthem will include a message directing the member to anthembluecross.com for detailed benefit information that provides INN/OON cost-sharing requirements. We will make the required changes to

any impacted ID cards that we issue with effective dates from January 1, 2022, and forward. ID cards will continue to be issued when required (e.g., any changes necessitating reissuance). For any needed reissuance for plan years on or after January 1, 2022, the changes were incorporated.

CAA Pharmacy and Other Health Reporting

The Consolidated Appropriations Act requires health insurers offering group or individual health coverage and self-funded (ASO) group health plans to report annual data to the Tri-Agencies on drug utilization and spending trends. The reporting must include total spending on healthcare services by type, such as for hospital, primary care, or prescription drugs. The reporting must also include rebate information and its effect on member costs.

The required reporting templates include:

- Plan Lists (Individual and Student, Group Health Plan List, and FEHB Plan List)
- Data Files (reporting of aggregated data based on state and market segment)
    - Premium and Life-Years Reporting
    - Spending by Category Reporting
    - Top 50 Most Frequent Brand Drugs Reporting
    - Top 50 Most Costly Drugs Reporting
    - Top 50 Drugs by Spending Increase Reporting
    - Rx Totals Reporting
    - Rx Rebates by Therapeutic Class Reporting
    - Rx Rebates for the Top 25 Drugs Reporting
- Narrative Response

On August 20, 2021, the Tri-Agencies announced a delay in enforcement of the pharmacy reporting requirements until the issuance of new regulations. The new compliance date is December 27, 2022, for reporting years 2020 and 2021. Future years reporting will be due on June 1 annually (i.e., 2022 data will be due on June 1, 2023).

An Interim Final Rule was issued on November 17, 2021, including instructions for this reporting that were subsequently updated. We will continue to work with CMS and other impacted stakeholders to make recommendations to the Tri-Agencies in areas where the reporting requirements are unclear or reporting includes data that is not maintained by issuers.

Please refer to separate communication from Anthem and notes below regarding future years reporting.

NOTE: For JAA/MCS clients, please refer to the JAA/MCS FAQ document.
According to the reporting instructions, the reports may be submitted by different entities based on the information required in the report. For example, for a self-funded group, the TPA or Medical Issuer may submit the Spending by Category reporting, while the PBM submits pharmacy related reports such as the Top 50 Most Costly Drugs report.

Will Anthem submit the reporting to HHS?
For the 2020/2021 data year, Anthem has submitted the aggregated reporting data on our fully insured and ASO clients' behalf for the benefits we administer and maintain. This included submission of the pharmacy data through CarelonRx (formerly IngenioRx) for clients that have

integrated pharmacy with CarelonRx (formerly IngenioRx) through Anthem. If a client has a third-party or carveout vendor for any portion of the required data (e.g., carveout PBM, Stop Loss carrier), the client should work with the carveout vendor to ensure submission of that data which includes third party vendors who share claim information with Anthem for accumulator purposes.

Beginning with the filing of 2022 data due June 1, 2023, ASO groups or their delegates will be responsible for the filing of the D1 Premium and Life Years Report. This will also require the submission of a corresponding Plan Report by the ASO group. Starting with the 2022 data, Anthem did offer an opt in option which we anticipate offering annually, subject to future regulatory guidance.

- **What files is Anthem submitting by default?**
  - Anthem will continue to complete the following reporting on behalf of ASO and FI clients:
    - P2 – Group Health Plan List
    - D2 – Spending by Category Reporting (included in aggregate submission for the business we administer and maintain)
    - Narrative Response applicable to the Anthem business
  - We will continue to file the D1 reporting for Fully Insured Groups, Anthem Balanced Funding Small Group ASO Groups, and Small Group MEWAs in OH, MO, KY, IN, and GA
  - For the June 1, 2024, submission of 2023 data, ASO groups will be given an opt-in option if they want Anthem to submit the D1 report on their behalf for the business we administer and maintain.
  - For clients that have integrated pharmacy coverage through CarelonRx (formerly IngenioRx), we will also submit the aggregated data in the D3 – D8 Pharmacy specific reports.
  - If a client has a third-party or carveout vendor for any portion of the required data (e.g., carveout PBM, Stop Loss carrier), the client should work with the carveout vendor to ensure submission of that data. When prompted, the carveout vendor should select the value “group by same TPA” when submitting the D1.

- **How will Anthem aggregate data?**
  - We will submit at the Issuer/TPA level. While information on the Data Sheet (ex. D2) is aggregated at the state and market segment level, the filing will be submitted using the name Anthem company legal name/associated EIN in the fully insured contract or ASO agreement.

Exceptions:

We will continue to file the D1 reporting for Fully Insured Groups, Anthem Balanced Funding Small Group ASO Groups, and Small Group MEWAs in OH, MO, KY, IN, and GA leveraging the survey responses collected to calculate the aggregated averages required for the reporting. In the future, we plan to collect this data as a part of our enrollment and renewal processes.

For the June 1, 2024 submission of 2023 data, ASO groups will be given an opt-in option if they wanted Anthem to submit the D1 report on their behalf for the business we administer and maintain. A survey will be sent for groups that wanted to opt-in so that they could provide their premium information. The final due date to complete the opt-in survey will be communicated. We anticipate that we will have an annual opt-in / opt-out process subject to future regulatory guidance.

Why does Anthem offer a D-1 report opt-in for ASO clients?

In order to obtain all of the required information to file one consolidated D1 report, Anthem would have to collect, store, and report data from clients and third-party vendors. This presents concerns as this reporting includes financial and competitively sensitive data.

The Interim Final rule continues to evolve. In many cases, our ASO clients use one or more third-parties or carveout vendors to support their business including, but not limited to, PBMs, Behavioral Health vendors, and Stop Loss carriers.

In addition, the D1 reporting includes other data elements such as the employer and employee premium contribution which we do not currently collect and maintain. The safe harbor regarding reporting of non-collected member and employer contributions on the D1 report expired after the December 27, 2022, reporting.

How will Minimum Premium groups be considered?
Minimum Premium will be considered as fully insured for the purpose of this regulation; therefore we will continue to complete the D1 report filing for Minimum Premium groups.

If as an ASO group I choose to file my own D1 reporting, where can I find information about the required filing?
You can find information regarding the filing requirements at the following CMS site: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection

Below are additional details on reporting materials and HIOS portal registration that may be helpful to you and your organization. All the information you need is on the CMS website.

CMS Materials for RxDC Reporting
On the CMS website, you can find information on current materials related to the Prescription Drug Data Collection (RxDC) reporting along with instructions and FAQs on how to complete the submission. Available resources include:

- Reporting instructions along with reference guides and forms needed for submission.
- RxDC templates that contain the Plan List (P2) and Data Sheet (D1).

Register for HIOS Portal
The HIOS Portal User Manual PDF provides instructions on obtaining access for your organization's filing. The HIOS Portal RxDC Quick Reference Guide PDF explains the file submission and upload process. Both can be found on the CMS website, in the HIOS Manuals section. Use these resources to help you register for HIOS Portal access and to complete your P2 and D1 reporting submissions by June 1 annually.

- Register as your organization (not as associated carrier, TPA, or PBM) by entering the contact information of the point person from your company.
- Request the role as RxDC submitter by entering the contact information for a second person from your company (a different person than who completed the initial registration).
- Check the status of the RxDC submitter role when logged in.

- Upload your organizations' RxDC submissions prior to annual due date. This is currently June 1 but is subject to change based on CMS guidance.
- View the upload status and fix any errors during the upload process.
- Retain your confirmation number once your submission is complete.
- Contact CMS Help Desk for questions or if help is needed.

It's important that you and your organization stay up to date on reporting guidance from CMS.
Once registered via the HIOS portal, you'll be able to keep current on available materials and filing requirements by attending CMS webinars or using other on-demand resources designed to help you stay informed. Prior to the submission date, CMS may offer alternative ways to submit a Plan List and Data Sheet by an employer. For example, CMS previously offered filing by email to group health plans via the FAQs issued on December 23, 2022, for prior reporting years.

If you want to receive an email when the RxDC resources are updated, create a Registration for Technical Assistance Portal (REGTAP) account at https://regtap.cms.gov. Select the checkbox "Please send me updates for the Consolidated Appropriations Act / No Surprises Act" in your account settings.

REGTAP serves as a centralized information portal for the CMS resources and training related to the Affordable Care Act Health Insurance Marketplaces, the Consolidated Appropriations Act, 2021 (CAA) including the No Surprises Act and other CMS policies. Registered users can access a library of resources, search FAQs, view Computer Based Trainings, submit inquiries, and register for training events.

Will you submit the data individually by client?
No, according to the instructions, issuers are to submit the report in aggregate (combining all data) for each reporting entity and market segment. For example, a reporting entity such as a medical issuer that is submitting the Spending by Category report, would aggregate all of the data for each applicable market segment.

Will there be a cost for completing the reporting?
At this time, there will be no additional charge for this reporting specifically; however, the new regulations will be taken into consideration when determining our administrative fee.

How will Anthem provide notification in writing that they will complete this reporting on behalf of the client?
For self-funded groups, beginning with November 1, 2022, renewals, Anthem will add language to Section B of its ASO Agreement to document the reporting that will be completed on behalf of an ASO client. For our fully insured policyholders, the notice we previously provided serves as our agreement to complete this reporting on the client's behalf for the benefits we administer and maintain.

How will the data be aggregated?
The reporting will be aggregated by Anthem Company, State, and Market Segment. Anthem will report the business under the state/company where the policy or plan was written. This is the same legal entity that is included in the fully insured group contract or ASO agreement.

The reports will include client data, but the reporting will not be client specific. The clients included in the reporting will be identified in the required plan reports.

The P2 report requires a Form 5500 Number. What is this number?
The 5500 Plan ID is a 3-digit number that designates one plan from another for the IRS and Department of

Labor (DOL). These numbers are to begin with 501 for a company's first health & welfare plan.

Will all groups have a Form 5500 Number?
No. Any plan sponsored or maintained by an employer to provide benefits to employees or former employees and their covered dependents is an ERISA plan. All ERISA plans are required to have a 5500 Plan ID regardless of the size of the plan. Plans established by any government, government agency, municipality, or church plan would not be considered an ERISA plan and would not have a form 5500 number.

How will Anthem identify the Form 5500 Number included in the Plan reporting?
For the initial reporting year, we used the Department of Labor Form 5500 search functionality: https://www.efast.dol.gov/5500search/. For June 1, 2023, we used a combination of client survey response and the Department of Labor Form 5500 search functionality: https://www.efast.dol.gov/5500search/ to populate the Form 5500 Plan ID. We plan to request this data as a part of our enrollment and renewal processes in the future.

For clients that had coverage with Anthem during the reporting period, but have termed, will Anthem include the data for the time period in which the client was active in their aggregate reporting?
Yes, Anthem will include the client's data in our aggregate reporting for the time period in which the client was covered.

Will clients be informed when the reporting has been submitted?
Anthem will communicate to clients once aggregate reporting is submitted.

Where are the reports to be submitted?
Reports are to be submitted to HHS through their Health Insurance and Oversight (HIOS) system. HIOS is an application within the CMS Enterprise Portal https://portal.cms.gov/portal/.

Prohibition on Gag Clauses

The CAA Gag Clause provision prohibits group health plans and health insurance issuers offering group health insurance coverage from entering into an agreement between a plan or issuer and a healthcare provider, network or association of providers, third-party administrator, or another service provider offering access to a network of providers that would directly or indirectly restrict a plan or issuer from disclosing or accessing certain price and quality information.

In addition, group health plans and issuers are required annually to submit an attestation to confirm compliance with the prohibition on gag clauses.

For fully insured, Anthem Balanced Funding, and MEWA groups, we will complete the annual attestation on your behalf for the business and information that we administer and maintain.

If you have a third-party or carveout vendor for any portion of the required data requiring attestation (e.g., carveout PBM) please work with the carveout vendor on the approach for attesting their data. Reference the following CMS link for submission instructions on how to complete this attestation: https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance

For ASO groups, we are providing you with the following confirmation of compliance, that will allow you to complete the attestation on the CMS HIOS portal:

> *Anthem represents that the administrative services provided under its Administrative Services agreements are consistent with the requirements set forth in Section 201 of the Consolidated Appropriations Act, 2021.*

This attestation statement applies only to the business and information that we administer and maintain.

For all clients completing your own attestation, the required attestation was due December 31, 2023. If you have a third-party or carveout vendor for any portion of the required data requiring attestation (e.g., carveout PBM) please work with the carveout vendor on the approach for attesting their data. Reference the following CMS link for submission instructions on how to complete this attestation: https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance

For the 2023 attestation requirement, Anthem submitted the attestation on our ASO client's behalf upon request for the business and information we administer and maintain.

Anthem sent a survey to ASO groups. Groups that wanted Anthem to submit this attestation on their behalf had to respond to the survey by August 15, 2023. If no survey response was received by the due date, we assumed that the client will complete their own attestation.

Will Anthem include the attestation for third party vendors (a vendor hired by the employer to administer specific benefits such as Pharmacy or Behavioral Health) as a part of their attestation?
No, Anthem will only attest for the business and information we administer and maintain.

If I have pharmacy coverage through CarelonRx integrated with my Anthem plan, will Anthem include the pharmacy coverage as a part of their attestation?
Yes, Anthem will attest to compliance with the gag clause prohibition for pharmacy coverage that is a part of your Anthem plan.

Have your participating provider contracts been revised to remove any language that restricts cost information sharing except for reasonable restrictions as permitted by the CAA, to allow plan sponsors to complete the attestation required?
Anthem's provider contracts are administered to comply with the law, including the restrictions placed on Gag Clauses by the CAA. Anthem will be attesting that its provider contracts are in compliance with the Gag Clause restrictions.

Will Anthem offer the same process to complete the 2024 calendar year Gag Clause attestation?
Yes, we will again offer ASO clients the opportunity to opt into Anthem's attestation upon completion of a survey by a specified date. For fully insured, Anthem Balanced Funding, and MEWA groups, we will complete the annual attestation on your behalf for the business and information that we administer and maintain.

Continuity of Care

The CAA requires Health Plans to provide in-network coverage for 90 days of continued care to

members whose provider or facility leaves the health plan's network when the member is undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non- elective surgery, or terminally ill.

On August 20, 2021, the Tri-Agencies released FAQs noting that they will issue regulations to implement the continuity of care requirements but will not do so prior to January 1, 2022. Plans and issuers are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date. Anthem has moved forward with a focus on that good faith compliance including enhancing the current process in which a member receives notice when a provider they have seen in the past year leaves the Anthem network. We will continue to monitor for additional regulatory guidance.

Anthem will notify a member if a provider they see regularly leaves the health plan's network. The communication will advise the member of the qualifications in which they may be eligible for continued care at in-network rates for a limited time period. Members who are undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill would be eligible. If a member believes they are eligible based on the criteria outlined in the communication, they are guided to contact member services for confirmation of eligibility and to initiate the continued care under in-network rates where approved.

If a fully insured group terminates with Anthem, members that are seeing a provider regularly will receive notification from Anthem which will advise the member of the qualifications in which they may be eligible for continued care at in-network rates for a limited time period. Members who are undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill would be eligible if the provider would not be in-network under their new plan. If a member believes they are eligible based on the criteria outlined in the communication, they are guided to contact member services for confirmation of eligibility and to initiate the continued care under in-network rates where approved.

How will state mandates apply for Continuity of Care?
State Continuity of Care mandates may be different than Federal and will also be considered as applicable for the determination of continuity of care. Please contact the number on the back of your ID card for any questions regarding the specific state and Federal qualifications.

Does a Do Not Contact provision in a contract prevent Continuity of Care letters from being generated to potentially impacted members?
No, Federally mandated communications are required to be sent regardless of any Do Not Contact contract provisions.

State All Claims Payer Databases

Please share Elevance Health and its affiliated health plans' intention to comply with the Secretary of Labor's standardized reporting format for voluntary reporting to State All Payer Claims Databases. Please comment on your expected timing according with the new regulations. Please delineate the impact, if any, on the administrative fees as a result of these changes.

We currently have plans in multiple states with All Payer Claims Databases (APCD) existing or in

implementation phases (e.g., California, Connecticut, Indiana, Georgia, Maine, New York, New Hampshire, Virginia). Elevance Health and its affiliated health plans submit data pursuant to each state's requirements. Additionally, Elevance Health and its affiliated health plans intend to submit data to any other states creating an APCD and utilize the standard format where applicable. Specific information regarding satisfaction of this requirement, including additional costs, is unavailable at this time as the format and state adoption is currently unknown.

Air Ambulance Reporting

The Consolidated Appropriations Act requires group health plans and health insurance issuers to report information about claims data for air ambulance services and such other information regarding air ambulance services as specified by the Secretary of HHS.

The CAA also requires providers of air ambulance services to submit information regarding air ambulance services, including air ambulance providers' transportation and medical costs, information on each provider's bases and aircraft, the number of air ambulance transports by payor and other information about transports, data on claims denials, and other information specified by the Secretary of HHS.

A proposed regulation on the Air Ambulance reporting provision of the Consolidated Appropriations Act was issued on September 16, 2021, with a request for comments/feedback.

When is the Air Ambulance Reporting due?
According to the proposed regulation, the reporting is required for two years only. While the proposed regulation indicated a March 31, 2023, initial filing date, at this time there is no final regulation providing the needed details for submission. The CAA statute does not require submission of this reporting until a final regulation is issued.

How will the reporting be used?
The Secretary of HHS, in consultation with the Secretary of Transportation, will issue a comprehensive public report summarizing the data and providing an assessment of the state and certain aspects and characteristics of the air ambulance market.

Will Anthem submit the reporting on behalf of clients?
Anthem is moving forward with the development of the reporting based on the proposed regulation with the intent to submit the reporting on behalf of our Fully Insured and ASO Clients for the claims we administer. We will continue to monitor and provide updates as additional regulatory detail is received.

Will this reporting be client specific?
No, the reporting will include all air ambulance claims for the Anthem company.

Agent/Broker Disclosures

Included as a part of the CAA were provisions related to Broker and Consultant Compensation disclosure and reporting. These provisions require brokers and consultants to disclose to group health plan sponsors any direct or indirect compensation they receive for brokerage services or consulting. For individual

health insurance coverage and short-term limited-duration insurance coverage, a health insurance issuer must disclose to enrollees, and report to the Dept of Health and Human Services (HHS), any direct or indirect compensation that the issuer pays to an agent or broker associated with the plan section and enrolling individuals in the coverage.

Who is responsible for disclosure and reporting of the compensation?
For group business, the Broker or Consultant (including their affiliates and subcontractors) is responsible for disclosure and reporting. For individual business and short-term limited-duration business, the insurer is responsible for disclosure and reporting.

A proposed regulation specific to the requirements for disclosing and reporting Agent/Broker compensation for individual and short-term limited-duration business was issued on September 16, 2021, with a request for comments and feedback. Anthem has provided feedback on the proposed regulations to CMS and is developing the individual and short-term limited-duration business compensation disclosure based on the proposed regulation guidelines. The CAA statute does not require submission of this reporting until a final regulation is issued.

ASO Agreement

Article 1, Consolidated Appropriations Act ("CAA"). The Consolidated Appropriations Act of 2021 (42 USC 300gg, et seq. and 29 USC 1185, et seq.), as amended, and regulations promulgated thereunder.

Article 1, Paid Claim Definition, subparagraph (5):

5. Claims Payment Pursuant to any Judgment, Settlement, Legal or Administrative Proceeding. Subject to Article 16 as applicable, Paid Claims shall include any Claim amount paid as the result of a settlement, judgment, or legal, regulatory, or administrative proceeding brought against the Plan and/or Anthem, or otherwise agreed to by Anthem, with respect to the decisions made by Anthem regarding the coverage of or amounts paid for services under the terms of the Plan. Paid Claims also includes any amount paid as a result of dispute resolution procedures.

Article 2(b)(4):

4. Administration of independent dispute resolution process for non-Network Provider Claims (including non-network air ambulance Provider Claims) as set forth under the CAA or, if applicable, through state law with Employer election as required, for the fee set forth in Section 3.C of Schedule A. Employer agrees to promptly notify Anthem if an independent dispute resolution request is received. Failure to promptly notify Anthem may impact independent dispute resolution process.

Article 2(aa):

aa. Anthem shall provide reporting as indicated in Schedule B to assist with compliance under the CAA.

Article 10(f):

This Agreement shall not be construed to restrict the use or disclosure of information that: (1) is public knowledge other than as a result of a breach of this Agreement; (2) is independently developed by a Party not in violation of this Agreement; (3) is made available to a Party by any person other than the other Party, provided the source of such information is not subject to any confidentiality obligations with respect to it; (4) is required to be disclosed pursuant to law, order, regulation or judicial or administrative process, but only to the extent of such required disclosures and after reasonable notice to the other Party; or (5) is required to be disclosed to a Member.

Section 3.C of Schedule A:

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

Schedule B:

Other Services Required by Federal Law not Otherwise Specified in the Agreement (as of the applicable

effective date):

- For Claims that qualify as no surprises Claims, Anthem shall calculate and apply the Member's cost share at the in-network benefit level using the recognized amount (Qualified Payment Amount). Anthem shall post a disclosure of the patient protections against balance billing on anthembluecross.com and shall include applicable language in Claim denial notices and explanations of benefits.
- Prepare advanced explanations of benefits to Members after receiving notice of scheduled services from a Provider
- Provide cost transparency tool/self-service access
- Provide for continuity of care administration for Provider termination from the network
- Provide air ambulance Provider reporting
- Provide aggregated reporting as required under Section 204 of the CAA for the services that Anthem administers under the Agreement. This reporting does not include the D1 Premium and Life Years report.
- Anthem represents that it is administering its Provider agreements consistent with the requirements set forth in Section 201 of the CAA. Anthem will provide a statement of compliance to Employer pertaining to Section 201 of the CAA on an annual basis.
- Upon request, Anthem will provide the non-quantitative treatment limitation analysis for the standard services that Anthem provides under the Agreement. Anthem will also provide reasonable assistance to Employer in the event of a regulatory audit for compliance with the Mental Health Parity and Addiction Equity Act.
- Post machine readable files on a monthly basis for the services Anthem administers for the Plan on anthembluecross.com.