Exhibit "A"

Anthem BlueCross BlueShield

# SELF INSURED RENEWAL PROPOSAL

GROUP NAME: **City of Joplin**

DATE: 9/12/2017

## ACCOUNT SUMMARY

| | |
|---|---|
| MARKETING REP: | Broz, Alvina |
| BROKER COMMISSIONS: | 0.00% LEVEL |
| CONTRACT YEAR: | 01/01/2018 THRU 12/31/2018 |
| CURRENT CONTRACTS: | 512 |
| CURRENT MEMBERS: | 1,230 |
| TYPE OF FUNDING: | ASO WITH STOP LOSS |
| SIC CODE: | 9111 |

Anthem BlueCross BlueShield

# SELF INSURED ACCOUNT INFORMATION

| | |
|---|---|
| Group Name: | City of Joplin |
| Effective Date: | 01/01/2018 THRU 12/31/2018 |
| SIC Code: | 9111 |
| Proposed PBM: | Anthem (ESI) |

## Current Account Information

| | |
|---|---|
| Current Funding Method: | ASO WITH STOP LOSS |
| Current Carrier or TPA: | 0 |
| If Current Anthem; Original Effective Date: | 1/1/2011 |

## Requested Specific Stop Loss Coverage

| | |
|---|---|
| Specific Stop Loss Level: | $150,000 |
| Lifetime Maximum: | Unlimited |
| Annual Maximum: | Unlimited |

### *Coverages under Specific Stop Loss*

| | |
|---|---|
| Medical: | Yes |
| Rx: | Yes |
| Dental: | No |
| Vision: | No |
| Contract Basis: | Paid |

## Requested Aggregate Stop Loss Coverage

### *Coverages under Aggregate Stop Loss*

| | |
|---|---|
| Medical: | No |
| Rx: | No |
| Dental: | No |
| Vision: | No |
| Annual Maximum: | |
| Contract Basis: | |
| Margin: | |

Anthem BlueCross BlueShield

# SELF INSURED RATES INFORMATION

| | |
|---|---|
| Group Name: | City of Joplin |
| Effective Date: | 01/01/2018 THRU 12/31/2018 |
| Employees: | 512 |
| Members: | 1,230 |
| Specific Stop Loss Level: | $150,000 |

## COMPOSITE RATES

| | Current | Renewal | % Change |
|---|---|---|---|
| Administration Fees * | $41.10 | $41.10 | 0.0% |
| Brokers Commissions | $0.00 | $0.00 | - |
| Bluecard Fees | $0.00 | See Note Below | - |
| Specific Stoploss | $79.28 | $86.44 | 9.0% |
| **Total Fixed Costs** | **$120.38** | **$127.54** | **5.9%** |

** Admin fee Includes $5000 Wellness fund*

-

## TIERED RATES

| Enrollment | 512 | 245 | 45 | 31 | 191 |
|---|---|---|---|---|---|
| | Composite | EE | ES | EC | FAM |
| Administration Fees | $41.10 | $41.10 | $41.10 | $41.10 | $41.10 |
| Brokers Commissions | $0.00 | | | | |
| Bluecard Fees | See Note Below | | | | |
| Specific Stoploss | $86.44 | $40.24 | $128.82 | $128.82 | $128.82 |
| **Total Fixed Costs** | **$127.54** | **$81.34** | **$169.92** | **$169.92** | **$169.92** |

## ANNUALIZED TOTAL COSTS

| | Current | Renewal | % Change |
|---|---|---|---|
| Administration Fees | $252,518 | $252,518 | 0.0% |
| Brokers Commissions | $0 | $0 | - |
| Bluecard Fees | $0 | See Note Below | - |
| Specific Stoploss | $487,068 | $531,065 | 9.0% |
| **Total Fixed Costs** | **$739,586** | **$783,583** | **5.9%** |

***BlueCard Fees are billed as claim as they are presented; BlueCard Fees are not covered under the Aggregate or Specific Stop Loss.

City of Joplin
Group Authorized Signature

# Your Summary of Benefits

Anthem BlueCross BlueShield

City of Joplin
Blue Preferred ® Select
Effective 01/01/2018

| Covered Benefits | Network | Non-Network |
|---|---|---|
| Deductible (Single/Family) | $500/$1,000 | $1,000/$2,000 |
| Out-of-Pocket Limit (Single/Family) | $1,500/$3,000 | $4,500/$9,000 |
| Physician Home and Office Services (PCP/SCP)<br><br>Primary Care Physician (PCP)/ Specialty Care Physician (SCP)<br>Including Office Surgeries and allergy serum:<br>o allergy injections (PCP and SCP)<br>o allergy testing<br>o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds,<br>o Pharmaceutical products | $25/$25<br><br>$5<br>No cost share<br>20%<br><br>No Cost Share | 40%<br><br>40%<br>40%<br>40%<br><br>40% |
| Preventive Care Services<br>Services included but not limited to:<br>o Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening<br>o Immunizations through age 5 | No copayment/coinsurance<br><br>No cost share | 40%<br><br>No cost share |
| Emergency and Urgent Care<br>Emergency Room Services<br>o facility/other covered services (copayment waived if admitted)<br>Urgent Care Center Services<br>o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products<br>o Allergy injections<br>o Allergy testing | $150<br><br>$50<br>NCS<br><br>$5<br>No cost share | $150<br><br>40%<br>40%<br><br>40%<br>40% |
| Inpatient and Outpatient Professional Services<br>Include but are not limited to:<br>o Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams | 20% | 40% |
| Blue 8.0 500 Series | | |

Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

# Your Summary of Benefits

| Covered Benefits | Network | Non-Network |
|---|---|---|
| **Inpatient Facility Services**<br>Unlimited days except for:<br>o 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)<br>o 90 days Network/Non-Network combined for skilled nursing facility | 20% | 40% |
| **Outpatient Surgery Hospital/Alternative Care Facility**<br>o Surgery and administration of general anesthesia | 20% | 40% |
| **Other Outpatient Services**<br>(including but not limited to):<br>o Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.<br>o Home Care Services 90 visits (excludes IV Therapy) (Network/Non-Network combined)<br>o Durable Medical Equipment, Orthotics and Prosthetics<br>o Physical Medicine Therapy Day Rehabilitation programs<br>o Hospice Care<br>o Ambulance Services | 20%<br><br>20%<br>20% | 40%<br><br>40%<br>20% |
| **Outpatient Therapy Services**<br>**(Combined Network & Non-Network limits apply)**<br>o Physician Home and Office Visits (PCP/SCP)<br>o Other Outpatient Services @ Hospital/Alternative Care Facility<br>Limits apply to:<br>o Physical/Manipulation therapy excluding Chiropractic Services: 60 visits<br>o Occupational therapy: 60 visits<br>o Chiropractic Services: 26 visits(Network only)<br>o Speech therapy: Unlimited visits<br>o Cardiac Rehabilitation: Unlimited<br>o Pulmonary Rehabilitation: Unlimited | <br><br>$25/$25<br>20% | <br><br>40%<br>40% |
| **Accidental Dental Services $3,000 per accident**<br>(Network and Non-network combined) | Copayments/Coinsurance based on setting where covered services are received | 40% |

# Your Summary of Benefits

| Covered Benefits | Network | Non-Network |
|---|---|---|
| **Behavioral Health Services[2]:**<br>**Mental Health and Substance Abuse**<br>**(Network and Non-Network)**<br>o Inpatient Facility Services<br>o Physician Home and Office Visits (PCP/SCP)<br>o Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional | Benefits provided in accordance with Federal Mental Health Parity | 40% |
| **Human Organ and Tissue Transplants[3]**<br>o Acquisition and transplant procedures, harvest and storage. | No cost share | 30% |
| Prescription Drugs<br>**Network Tier structure equals 1/2/3 (and 4, if applicable)**<br>o **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip<br>o **Anthem Rx Home Delivery Service:** (90-day supply) Includes diabetic test strip<br>Member may be responsible for additional cost when not selecting the available generic drug.<br>Members have additional cost with retail supply greater than 30 days.<br><br>Medicare Rx - Wrap<br>**Specialty Medications** must be obtained via our Specialty Pharmacy network in order to receive network level benefits.<br>Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order. | \$10/\$30/\$50<br><br>\$25/\$75/\$125<br><br>RX has a separate Out of Pocket Maximum \$5,100/\$10,200<br>This includes all pharmacy charges | 40%[5]<br><br>Not covered<br><br>RX has a separate Out of Pocket Maximum \$10,200/\$20,400<br>This includes all pharmacy charges |

Notes:

- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and a percentage (%) coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- No cost share (NCS) means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the office visit setting.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Live Health Online (LHO) is covered at the PCP costshare.

# Your Summary of Benefits

- Certain diabetic and asthmatic supplies, except diabetic test strips, have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies.
- Benefit period = calendar year
- Elective abortions are not covered.
- Mammograms (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime

1. These covered services for age 6 and above are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit
2. We encourage you to review the Schedule of Benefits for limitations. .
3. Kidney and cornea are treated the same as any other illness and subject to the medical benefits.
4. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

**Precertification:**
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

**Pre-existing Exclusion Period: NONE**

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

| | |
|---|---|
| Authorized group signature (if applicable) | Date |
| Underwriting signature (if applicable) | Date |

Anthem BlueCross BlueShield

# SELF INSURED BENEFIT PAGE

Group Name: City of Joplin
Effective Date: 01/01/2018 THRU 12/31/2018
SIC Code: 9111

| Option # | 1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Option Label | PPO | | | | | | | | | | |
| Lumenos Plan | NO | | | | | | | | | | |
| RX Formulary | National | | | | | | | | | | |
| **Network** | Blue Preferred Select | | | | | | | | | | |
| **Plan Design Summary** | **In Network** | **Out of Network** | **In Network** | **Out of Network** | **In Network** | **Out of Network** | **In Network** | **Out of Network** | **In Network** | **Out of Network** |
| **Deductible** | | | | | | | | | | |
| Individual | $500 | $1,000 | | | | | | | | |
| Family | $1,000 | $2,000 | | | | | | | | |
| **Coinsurance** | 80% | 60% | | | | | | | | |
| **Out of Pocket Maximum** | | | | | | | | | | |
| Individual | $1,500 | $4,500 | | | | | | | | |
| Family | $3,000 | $9,000 | | | | | | | | |
| **Copays** | | | | | | | | | | |
| Primary Care Physician | $25 | ded/coin | | | | | | | | |
| Specialist Physician | $25 | ded/coin | | | | | | | | |
| Urgent Care | $50 | ded/coin | | | | | | | | |
| Emergency Room | $150 | $150 | | | | | | | | |
| **Inpatient Hospital** | ded/coin | ded/coin | OPTION NOT AVAILABLE | | OPTION NOT AVAILABLE | | OPTION NOT AVAILABLE | | OPTION NOT AVAILABLE | |
| **Outpatient Surgery** | ded/coin | ded/coin | | | | | | | | |
| **Prescription Drugs** | | | | | | | | | | |
| Rx Deductible | N/A | N/A | | | | | | | | |
| ***Retail*** | | | | | | | | | | |
| Tier 1 | $10 | 50% (min $60) | | | | | | | | |
| Tier 2 | $30 | 50% (min $60) | | | | | | | | |
| Tier 3 | $50 | 50% (min $60) | | | | | | | | |
| ***Mail Order*** | | | | | | | | | | |
| Tier 1 | $25 | Not Covered | | | | | | | | |
| Tier 2 | $75 | Not Covered | | | | | | | | |
| Tier 3 | $125 | Not Covered | | | | | | | | |

# SELF INSURED ASSUMPTIONS AND CONDITIONS (With StopLoss)

This contract will be issued in Missouri.

The proposed services, rates and fees are effective from 01/01/2018 THRU 12/31/2018.

Our quote assumes that 512 employees will be enrolling for medical coverage, with an average member to employee ratio of 2.40.

Anthem Blue Cross and Blue Shield reserves the right to revise this proposal or modify these rates under any of the following circumstances:

- Due to any taxes, fees and assessments prescribed by any statutory, regulatory or other legal authority, that in Anthem Blue Cross and Blue Shield's discretion, invalidates this quote.
- Should the employer implement benefit changes that result in substantial changes in the service or networks, as determined by Anthem/Blue Cross and Blue Shield.
- Change in nature of Employer's business.
- Should the total enrollment or enrollment distribution by membership type, product or location change by 10% or more from that assumed when preparing the pricing for this package.
- If legislative and/or regulatory changes or mandates materially impact the stop loss policy or the Employer's plan documents. Plan documents shall include the documents that set forth the terms of the plan.
- Changes in proposal terms, conditions, services or product from this quotation.

Anthem Blue Cross and Blue Shield's proposal assumes claims incurred prior to the initial effective date are not included unless specifically noted.

The proposal assumes the same enrollment for Medical/Rx and is subject to Anthem's enrollment assumptions.

## Caveats

This renewal proposal expires 90 days from the date of its release or on the effective date shown above, whichever is sooner.

Under the Specific Paid option, the accumulation for stoploss will be incurred 01/01/2011 thru 12/31/2018, and paid 01/01/2018 thru 12/31/2018.

The annual specific attachment for specific point is per member per contract period.

The specific maximum liability for any individual will be UNLIMITED.

The renewal notification will be provided no sooner than 120 days prior to the renewal effective date.

Proposed rates are payable by the invoice due date.

Proposed specific stop loss rates assume that the employer will continue its current level of contributions.

Proposed specific stop loss rates assume that 100% of eligible employees and dependents will participate if noncontributory and 75% will participate if the plan is contributory of those not electing the plan offered by City of Joplin.

Specific Stop Loss Attachment points include paid Medical/Rx claims.

Stop Loss protection must be purchased in conjunction with our Administrative Services proposal

No change in benefits provided by the group's employee benefit program shall be covered by the stop loss agreement nor shall any amounts paid as benefits resulting from such a change be counted towards the satisfaction of the attachment point. This limitation may be waived if a written acceptance of such a change is issued by the carrier.

Only those coverage's quoted and which are eligible under the group's employee benefit program are eligible under this stop loss program.

An eligible employee is defined as an active, permanent employee who works for pay or profit at least 30 hours per week, 50 weeks per year as of the effective date and who completes the group imposed waiting period.

Anthem/Blue Cross and Blue Shield requires that City of Joplin contributes a minimum of 50% of the employee premium for all active and retired employees enrolled in the group health plan.

Specific Stop loss claims above the selected specific stop loss deductible limit will NOT count towards satisfaction of the aggregate attachment point.

Please refer to our specimen ASO and Stop Loss Agreements for complete details.

This proposal assumes that:

- Anthem/Blue Cross and Blue Shield will be the only carrier offered.
- Fees quoted include commissions of 0.00% LEVEL.
- If City of Joplin is delinquent in payment for the weekly claims billing, Anthem Blue Cross and Blue Shield will not process further claims until the account is brought current. This applies to both the active period and the 12-month period following termination.
- The health benefit plan(s) reflected in this proposal is (are) considered to be grandfathered under the provisions of the health care reform law.
- Please be aware that changing your benefit plan, employer premium contribution approach or insurance carrier will, in most situations, cause your plan offering to no longer be considered grandfathered. In these instances, you will then be required to implement additional provisions of the Affordable Care Act.

The health benefit plan(s) reflected in this proposal is not considered to be grandfathered under the provisions of the Patient Protection and Affordable Care Act. Non-grandfathered plans are subject to additional provisions under the Patient Protection and Affordable Care Act that do not apply to grandfathered plans. For further information, please contact your account representative.

ASO fees and stop loss premiums will be invoiced on the first full week of the month and due within three business days. Claims are billed weekly.

The following BlueCard fees will be included on the ASO invoice OR in the paid claims amount: The Access Fee is charged at a percentage no greater than 4.30% of the discount/differential subject to a maximum of $2,000 per claim. The AEA Fee is $5.00 per professional provider claim and $11.00 per institutional claim. Occasionally, Anthem and a Host Blue may contract for a lower fee by combining the Access Fee and the AEA fee. For a complete description of these fees, please consult your ASO Agreement.

If this proposal is not accepted in writing within 90 days from its issuance, it is null and void.

A change in the contract period will require a recalculation of fees.

Stop Loss rates are ILLUSTRATIVE due to the gap in the experience period and effective date of coverage. We will provide a firm quote, after reviewing claims paid by month with contracts by month as well as large claims detail at a member level (current status, diagnosis, and prognosis) to within four (4) months of the contract effective date.

Section 1341 of the Affordable Care Act (ACA or health care reform law) provides that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. This quote or renewal does not include the ACA Reinsurance Fees, since it is assumed that the employer will remit payment to HHS directly.

Please note: For groups effective 1/1/2014 and after, we do not know at this time if additional guidance and clarification from the US Department of Health and Human Services will require additional changes to rates and benefits. For clarification purposes:

- IRS has jurisdiction over the Insurer Fee, while HHS has jurisdiction over Reinsurance Fee.
- Rates and benefits for most large groups are likely to change. Further communication will be sent as soon as additional information becomes available.

Under final rules issued by EEOC Under the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act, wellness incentives are subject to certain limits in some situations. Incentive limits may also apply Under the Affordable Care Act. Employers are responsible for taking steps to comply with all legally-required Incentive limits. Please consult your attorneys or advisors for additional Information as needed.

A fee shall be charged for Anthem's oversight of Enhanced Personal Health Care with Providers or Vendors. Such fee shall be 25% of the per attributed Member Per Month amount charged to Employer for the Provider performance bonus portion of the Enhanced Personal Health Care program.

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires that group health plan and group health insurers apply the same treatment and financial limits to mental health and substance abuse disorder benefits as they do to medical surgical limits. Anthem standard processes have been reviewed to comply with non-quantitative treatment limits. Plan sponsors are responsible for ensuring that their plan designs are compliant with all applicable federal laws governing plan design, including MHPAEA.

Since Anthem is neither a Hawaii authorized insurer nor a Hawaii Health Care Contractor, our benefits may not match the requirements of the Prepaid Health Care Act. We recommend that you obtain direct quotes for either an individual policy for employees who live and work in Hawaii or if there are several employees within an employer group to obtain group coverage from a Hawaii authorized insurer. This would ensure that all the state requirements are met.

Anthem BlueCross BlueShield

# Description of Anthem's Enhanced Personal Health Care Programs[1]

At Anthem Blue Cross and Blue Shield ("Anthem"), we believe that our health connects us all. We focus on developing long-term relationships that unite the siloes of healthcare—strengthening the bonds between patients and doctors, primary care providers, specialists, and hospitals —enabling seamless delivery of the right care at the right time.

We are committed to connecting our members to patient-centered care. What makes us unique is our approach to supporting delivery system transformation. Anthem incents providers through value-based payment and couples these incentives with a robust support system designed to assist practices in their transformation to patient-centered care.

Although there is growing broad-based support for a patient-centered care model, we understand that this shift will not happen spontaneously. Rather, it requires a concerted effort and active support from all key stakeholders in the delivery system to create an environment conducive for change. This includes:

- A redesign of current payment models to align financial incentives and to provide compensation for important clinical interventions that occur outside of a traditional patient encounter;
- Support for risk-stratified care management;
- Sharing meaningful information regarding patients that goes beyond the information captured in the physicians' medical record; and
- Providing physicians with the knowledge, information and tools they need to leverage the benefits of new payment models, along with support services and information exchange to help them transform the way they deliver care.

Anthem's Enhanced Personal Health Care programs are based on years of experience. Anthem has championed the patient-centered care model through our participation in patient-centered medical home programs across the country. The compelling results we saw in quality improvement and cost of care reduction convinced us to cement our commitment to patient-centered care. In our studies to date, we have observed improvement in compliance with evidence-based guidelines and a reduction in avoidable, unnecessary admissions and ER visits, along with measured maintenance or improvements in the quality of health care services.

Our Enhanced Personal Health Care programs are built upon the success of our patient-centered medical home programs and foster a collaborative relationship between Anthem and the contracted Provider. This relationship enables both the health benefits administrator and the Provider to leverage the other party's unique assets whether through clinical, administrative, or data expertise; and together, this partnership supports coordinated care with a focus on risk stratified care management, wellness and prevention, improved access and shared decision-making with patients and their caregivers.

We offer this Program Description to give you important information regarding Enhanced Personal Health Care program operations, including the methodology used to charge the employer and details about the reconciliation process. Our intent is to provide you with an easy to understand description of the key elements of the Program.

[1] This document is intended to be a description of the Payment Innovation Programs offered by Anthem Blue Cross Blue Shield. This document does not include a description of provider incentive programs offered or administered by the Blue Cross Blue Shield Association or any other Blue Cross and/or Blue Shield Plans.

## Program Description:

- These programs reward Providers (which may include Vendors) for successfully managing the quality and overall health care costs of Anthem members.
- These programs pay performance incentives, rewards, or bonuses (including shared savings) to Providers based upon the Providers' achievement of certain cost, quality, efficiency, or service standards and/or metrics.
- Some providers may also receive a clinical coordination payment for the clinical services they provide outside of a traditional office visit. Those services could include care planning, maintaining health registries, enhancing access (such as responding to emails or offering web-based visits) or following up with patients via phone or email to make sure that they fill new prescriptions. To participate in the Enhanced Personal Health Care program, Providers must meet consistent value-based criteria, which include, but are not limited to, the following:
    - 24/7 availability through extended hours and/or after hours call
    - Participation in our aligned care management and disease management model
    - Established, dedicated roles within the practice to support this program
    - Use of the Anthem's Member Medical History Plus (MMH+) system that provides a picture of the services patients may have received outside of the provider's practice
    - Use of a registry function to effectively manage their patient population and support population health management
    - Use of generic Rx substitutes where clinically appropriate
    - Achievement of appropriate performance on nationally-endorsed quality measures
    - Encouragement of the use of electronic medical records (EMR)
    - Some larger and/or more sophisticated providers have the capability to take on increased accountability as well as an adequate pool of patients for purposes of the shared savings model. These organizations, which may call themselves accountable care organizations (ACOs) or integrated health systems, are willing to assume the full risk of managing their patients independently, and typically have the following attributes:
        - a formal legal structure to receive and manage risk sharing;
        - a well-documented plan for improving patient safety, health status and reducing the cost of medical care;
        - a commitment to deploying an IT platform, including an electronic medical record and care management solution, supporting the capture, electronic exchange and analysis of clinical information across ambulatory, inpatient and ancillary (lab, imaging, eRx, etc.) settings and sharing key clinical data with Anthem;
        - the capability to assume a primary role in care planning and care management with support from Anthem resources for more complex patients;
        - strong physician leadership committed to a patient-centered care model and empowered to drive change across the provider organization.

## Methodology Used To Charge The Employer:

- We use a method we call "attribution" to match members with their providers. The foundation of attribution is to recognize existing provider relationships.
    - Attribution is used to identify the provider's patient population, defining which members the provider is responsible for and including those members on provider reports.
    - Attribution is the foundation for clinical coordination payments as well as shared savings calculations and payments.

- We use one of two processes for attribution, depending on the type of product in which the member is enrolled:
    - For products that do not require the selection of a primary care physician (PCP), such as Open Access PPO products, patients are attributed to the Provider they have seen most frequently in a 24-month period based on claims data. In case of a tie, priority will go to the Provider with whom the member has had the longest relationship. Attribution is updated quarterly based on updated claims and reconciled with eligibility each month.
    - For products that require the selection of a primary care physician, members will be attributed to the provider they select as a primary care physician. The attribution is updated monthly to reflect the selection.

- To understand how the Employer is charged, it is helpful to first understand how savings are calculated and how the Provider's share of the savings is determined.
    - First, we project the expected cost of health care services for attributed members, to establish a Medical Cost Target (MCT), by reviewing risk-adjusted historical claims costs for the Provider or a group of Providers and trending those costs forward. We sometimes group Providers together to ensure that the medical cost target is calculated on the basis of a statistically valid pool of patients.
    - Then the actual risk-adjusted costs incurred during the year are compared with the medical cost target. If the actual costs are less than the medical cost target and the Provider meets a quality threshold, then the Provider becomes eligible to receive a portion of the savings. If a Provider does not meet the quality threshold, the provider is NOT entitled to any bonus payment, regardless of the savings generated.
    - If the Provider meets the quality threshold and therefore is eligible to earn a performance bonus, the amount of the bonus will vary based on the Provider's performance on the quality measures. The higher a Provider's quality scores, the larger the bonus the Provider will receive, subject to a maximum payment amount. The expectation is that the Employer will also benefit from the lower overall costs.

- Provider performance bonuses are funded by the Employer through a fixed Per Attributed Member Per Month (PaMPM):
    - This is the amount we actuarially determine to cover the cost of the provider performance bonus.
    - This amount will be updated periodically based on Anthem's book of business.

## Reconciliation Process:

- All money collected for the Enhanced Personal Health Care programs will be used only for Enhanced Personal Health Care payments to Providers.

- Under the Fixed Per Attributed Member Per Month method, the charge to the Employer will be updated periodically based on experience and actuarial projections. Reconciliation will be completed periodically based on Anthem's self- insured book of business. Any surplus or shortfall will be applied to those forecasts when setting the future payment innovation payment.

    - Anthem may make additional payments to Providers or Anthem may receive payments from Providers based on the outcome of the measurement period. As a result of these periodic settlements with Providers, Anthem will adjust the fixed Per Attributed Member Per Month to reflect these settlements with Providers. Please note that member cost shares will not be affected by these settlements with Providers.

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