EXHIBIT "A"

Anthem BlueCross BlueShield

SELF INSURED RENEWAL PROPOSAL

GROUP NAME: **City of Joplin**

DATE: 8/26/2019

ACCOUNT SUMMARY

MARKETING REP:	Broz, Alvina
BROKER COMMISSIONS:	0.00% LEVEL
CONTRACT YEAR:	01/01/2020 THRU 12/31/2020
CURRENT CONTRACTS:	498
CURRENT MEMBERS:	1,165
TYPE OF FUNDING:	ASO WITH STOP LOSS
SIC CODE:	9111

Anthem BlueCross BlueShield

SELF INSURED ACCOUNT INFORMATION

Group Name:	City of Joplin
Effective Date:	01/01/2020 THRU 12/31/2020
SIC Code:	9111
Proposed PBM:	Anthem (IngenioRX)

Current Account Information

Current Funding Method:	ASO WITH STOP LOSS
Current Carrier or TPA:	Anthem
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

Anthem BlueCross BlueShield

SELF INSURED RATES INFORMATION

Group Name:	City of Joplin
Effective Date:	01/01/2020 THRU 12/31/2020
Employees:	498
Members:	1,165
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	$93.08	$102.35	10.0%
Total Fixed Costs	**$134.18**	**$143.45**	**6.9%**

Admin fee includes $5000 annual wellness fund. Admin fee guaranteed for 1/1/19 - 12/31/20

TIERED RATES

Enrollment	498	257	41	23	177
	Composite	EE	ES	EC	FAM
Administration Fees	$41.10				
Brokers Commissions	$0.00				
Bluecard Fees	See Note Below				
Specific Stoploss	$102.35	$65.73	$141.40	$141.40	$141.40
Total Fixed Costs	**$143.45**				

ANNUALIZED TOTAL COSTS

	Current	Renewal	% Change
Administration Fees	$245,614	$245,614	0.0%
Brokers Commissions	$0	$0	-
Bluecard Fees	$0	See Note Below	-
Specific Stoploss	$556,254	$611,625	10.0%
Total Fixed Costs	**$801,867**	**$857,239**	**6.9%**

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

Please refer to Assumptions and Conditions.

City of Joplin
Group Authorized Signature

Anthem BlueCross BlueShield

SELF INSURED BENEFIT PAGE

Group Name: City of Joplin
Effective Date: 01/01/2020 THRU 12/31/2020
SIC Code: 9111

Option #	1								
Option Label	BPS PPO								
HSA-HRA Plan	NO								
PBM 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 01/01/2020 THRU 12/31/2020.

Our quote assumes that 498 employees will be enrolling for medical coverage, with an average member to employee ratio of 2.34.

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.

Electronic eligibility or tape feeds must be in a format compatible with our systems. Eligibility data will be provided in Anthem's standard format. Additional charges may apply for non-standard formats.

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 12/31/2020, and paid 01/01/2020 thru 12/31/2020.

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 coverages 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. Anthem pays claims and then bills our ASO client for reimbursement. Anthem's standard for claim billing is weekly with payment required within three business days from receipt of invoice.

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 4.14% 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. The Central Financial Agency fee is $0.35 per payment notice. The ITS transaction fee is $0.05 per claims transaction. 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.

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.

Discounts are negotiated by our vendor, National Care Network on certain non-network claims. The fee will be equal to 50% of the negotiated savings.

The charge for discounts achieved for providers that participate in the Traditional network but not the PPO/POS network is equal to 50% of the negotiated savings.

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.

The final relationship between the Parties will be subject to and described in an Administrative Services Agreement and this agreement will be the binding agreement between the parties.

Fees associated with claims processed during the runout period including without limitation subrogation fees, recovery fees, network access fees, will be charged during the runout period.

Subrogation services – The charge is 25% of gross subrogation recovery.

Program Integrity / Overpayment Identification and Claims Prepayment Analysis Activities – The charge to Employer is 25% of (i) the amount recovered from review of Claims and membership data and audits of Provider and Vendor activity to identify overpayments and (ii) the difference between the amount Employer would have been charged absent prepayment analysis activities and the amount that was charged to Employer following performance of the prepayment analysis activities. This includes, but is not limited to, activities related to COB, duplicates, contract compliance, and eligibility.

External appeals - The PPACA requires that ASO groups provide a process for external claims appeals to be available in situations where adverse benefit determinations have been made. Employer may contract with Anthem for this service or arrange to work directly with an external vendor. The fee will be $550 per external appeal for the service contracted with Anthem.

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.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): 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. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.