



Village of Downers Grove

Report for the Village Council Meeting

Table 1 - Council Agenda item.

Subject	Employee Benefits Renewal Contracts and Medical Plan Amendments for Fiscal Year 2027
Submitted By	Lauren Linares, Director of Human Resources

Synopsis

Resolutions have been prepared to authorize approval of employee benefits renewal contracts and plan amendments for Fiscal Year 2027 and to authorize staff to remit weekly funding for health claims and associated administrative fees.

Strategic Plan Alignment

The 2025-2027 goals include *Steward of Financial, Environmental, and Neighborhood Sustainability*.

Fiscal Impact

The proposed Fiscal Year 2027 health insurance budget includes \$2,299,270 for claims administration, stop-loss contracts, and wellness initiatives. The vendors and contract amounts for Fiscal Year 2026 and Fiscal Year 2027 are itemized below:

Vendor	Contract Item	Fiscal Year 2027 Amount	Fiscal Year 2026 Amount
Blue Cross Blue Shield	Medical Claim Administration	(\$229,377)	(\$391,812)
Blue Cross Blue Shield	Specific and Aggregate Stop Loss	\$1,353,647	\$1,125,737
Subtotal		\$1,124,270	\$733,925
Delta Dental	Dental Insurance Administration	\$23,500	\$22,141
Humana	Retiree Carve Out	\$260,831	\$247,601
Professional Benefit Administrators	COBRA & Flexible Spending	\$10,285	\$10,000
HealthJoy	Care Navigation Platform	\$38,037	\$38,037
Total		\$1,456,923	\$1,051,704

Recommendation

Approval on the October 20, 2026 Consent Agenda.

Background

The recommended contracts provide the administration and support needed for the Village's Health Insurance program, which has a total Fiscal Year 2027 proposed budget of \$14.5 million.

A summary of the 2027 employee benefits contracts is provided below:

Medical Claim Administration – The Village has a self-funded medical plan and contracts with an outside vendor to provide claim administration on behalf of the Village. Claim administration includes adjudication of medical and prescription drug claims, pre-certification, and medical case management services. Annually, staff reviews the claim administration services received from the vendor. Staff also reviews the vendor's relationship with Preferred Provider Organizations (PPOs) to ensure the discounts received through PPO contracts are cost-effective for both the Village and its employees. The Village has contracted with Blue Cross Blue Shield of Illinois for these services since 2011 and will renew the contract into Fiscal Year 2027. The Village health insurance plan is consumer-centric and allows employees to participate in an annual wellness screening initiative. Employee participation drives a one-time wellness credit to the Blue Cross plan. The 2027 medical claims administration is an annual credit of \$229,377, resulting from medical rebate credits. Please note that the Benefit Program Application (BPA) identifies a weekly fee schedule, a change from the current monthly cycle. As a self-funded plan, BCBSIL requires the Village to fund claims weekly at its 2027 renewal. The resolution authorizes Village staff to remit payment for all undisputed health claims and associated administrative fees on a weekly basis without prior Village Council approval. The expenditures will subsequently appear on claims ordinances for Village Council ratification.

Stop Loss Coverage – The Village purchases stop-loss coverage to limit its financial exposure. Stop loss coverage provides insurance for catastrophic medical claims of participants in the Village's group health care plan. Stop-loss coverage comes in two types: specific and aggregate. Specific stop-loss insurance provides a point at which the insurance company becomes responsible for any claims after an individual insured reaches a predetermined limit in the contract year. As part of the annual review, staff directs the Village's consultant, MarshMMA, to recommend the most appropriate point for specific stop-loss coverage. The consultant reviews specific claim data for the Village's group and determines whether it is cost-effective for the Village to take on additional claim exposure. For 2027, the consultant determined that the Village should maintain the current \$150,000 specific stop-loss level. However, negotiations resulted in a 20% increase due to plan exposure related to the number of high claimants and claim severity. There are no changes to the aggregate stop loss coverage.

Dental Insurance – The Village provides employees with a dental program administered by Delta Dental Plan of Illinois. Under this program, employees use PPO network providers, receive services at discounted rates, and have benefits paid in full. Employees can also use out-of-network providers; however, they receive less comprehensive coverage. All administrative services, customer service, claims processing, underwriting, billing, network recruiting and management, enrollment, sales, and account service are conducted locally from Naperville, IL. Fiscal Year 2027 fees to administer the Delta Dental program are \$23,500, an increase of \$1,359 from Fiscal Year 2026.

Retiree Carve Out – Village employees and their eligible spouses on the Village’s Health Insurance Plan become eligible for the retiree carve out when becoming Medicare eligible at age 65. In 2012, through its broker, the Village found a Humana supplement plan to offer to Medicare-eligible retirees, thereby transitioning this group from the Village’s self-insured plan. The Village funds the premiums and invoices the respective retirees. Employees who retired before the Village Ordinance change on September 9, 2009, receive a 50% premium credit. Humana’s Fiscal Year 2027 rates are adjusting due to rising healthcare costs, changes to federal Medicare, and the Part D redesign under the Inflation Reduction Act (IRA). The Fiscal Year 2027 premium increased 3.1% from Fiscal Year 2026.

COBRA & Flexible Spending – Professional Benefit Administrators (PBA) provides medical, transit, parking, and dependent flexible spending accounts for Village employees, and administers continuation of health coverage (COBRA) for separating employees and their families. In 2025, PBA deployed a COBRA upgrade that lets participants view benefit letters, elect coverage, and make online payments. The Village incurs a single annual COBRA fee for this service. However, flexible spending fees vary monthly, depending on the number of participants. For Fiscal Year 2027, the contracted fee amounts increased .15 per flexible spending account participant per month, with no changes to the COBRA administrative fee.

HealthJoy – The Village provides employees access to a healthcare navigation platform to support participants’ physical and mental well-being by highlighting better care already offered by the Village’s current plan design. Members can connect with benefits experts, clinical consultants, and billing experts. Additionally, Teladoc Health will provide virtual care services. The rate for Fiscal Year 2027 will continue at \$38,037.

Attachments

Resolutions

Contracts

Resolution No.

A Resolution Authorizing Execution of a Renewal Agreement and Addendum Thereto Between the Village of Downers Grove and Blue Cross/Blue Shield of Illinois

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Benefit Program Application and Addendum thereto (the "Agreement"), between the Village of Downers Grove (the "Employer") and Blue Cross/Blue Shield of Illinois (the "Claims Administrator") for medical claim administration services effective January 1, 2027 through December 31, 2027, as set forth in the form of the Agreement submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Agreement, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. The Village Council further authorizes staff to remit payment for undisputed health claims and associated administrative fees on a weekly basis without prior Village Council approval. All such expenditures shall appear on subsequent claims ordinances for Village Council ratification.

4. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Agreement.

5. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

6. That this Resolution shall be in full force and effect from and after its passage as provided by law.

By: Mayor

Passed:

Published:

Attest:

By: Village Clerk

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, hereinafter referred to as "Claim
Administrator" or "BCBSIL"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 365058

Group Number(s): 438994

Section Number(s): See Account Structure

Legal Employer Name: Village of Downers Grove

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN MAY NOT BE NAMED.)

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Effective Date of Coverage specified below? ☐ Yes

If not, please specify your ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

ERISA Plan Administrator*: _____

Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:

Non-Federal - Municipality ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐ Yes

If not, please specify your Non-ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/day/Year) 01 / 01 / 2027

Anniversary Date: (Month/Day/Year) 01 / 01 / 2028

Retiree-Only Plan(s) Identification:

For more information regarding Retiree-only plans, contact your Legal Advisor.

Do you have one or more Retiree-only plan(s)? ☐ Yes ☒ No

If yes, please provide Benefit Agreement number, or group and section numbers of the Retiree-only plan(s):

Account Information

☒ NO CHANGES

☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9111

Employer Identification Number (EIN): 36-6005857

Address: 850 Curtiss Street

City: Downers Grove

State: IL

ZIP: 60515

Administrative Contact: Lauren Linares

Title: HR Director

Email Address: llinares@downers.us

Phone Number: 630-434-5538

Fax Number: 630-434-5484

Wholly Owned Subsidiaries to be covered:

Affiliated Companies to be covered:

Employer Identification Number (EIN): 36-6005857

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

IL GEN ASO BPA (Rev. 06.26) Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual
Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

(Affiliated Companies must be required or permitted to be aggregated per IRS Guidelines, Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m) or (o), or under applicable law.)

Blue Access for EmployersSM ("BAESM") Contact: Lauren Linares

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: llinares@downers.us

Phone Number: 630-434-5538

Fax Number: 630-434-5484

Producer of Record Information

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Effective: _____

If applicable, the below-named producer(s) or agency(ies) is/are recognized as Employer's Producer of Record (POR) to act as a representative in negotiations with and to receive commissions from BCBSIL, Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for Employer's employee benefit program(s). This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by the Employer.

Producer/Consultant Compensation:

The Employer acknowledges that if its POR acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's POR a commission and/or other compensation in connection with such services under the Administrative Services Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid to the POR by the Claim Administrator in connection with services under the Administrative Services Agreement, the Employer should contact its POR.

Are commissions to be paid? ☐ Yes ☐ No

If no, is there a designated Producer of Record, Consultant or Broker? ☐ Yes ☐ No

If yes, please provide: Producer or Agency Name: _____ Illinois Producer# or Consultant#:

Producer or Agency to whom commissions are to be paid*:

Illinois Producer#: (nine digits)

NPN:

Address:

City:

State:

Phone:

Fax:

Is Producer/Agency appointed with BCBSIL? ☐ Yes ☐ No

Commissions:

☐ PCPM \$ Does a Monthly Cap Apply ☐ Yes ☐ No \$ (If cap is annual, divide by twelve)

☐ Flat \$ Does a Monthly Cap Apply ☐ Yes ☐ No \$ (If cap is annual, divide by twelve)

☐ Percentage of Stop Loss: %

ADDITIONAL COMMISSIONS:

* The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

Schedule of Eligibility

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions:

1. Eligible Person means:

- ☒ A full-time employee of the Employer.
- ☐ A full-time employee of the Employer who is a member of: _____ (name of union)
- ☐ A part-time employee of the Employer.
- ☐ A retiree of the Employer. Define criteria:
- ☒ Other: Pre 65 Retirees

Are any classes of employees to be excluded from coverage? ☒ Yes ☐ No

Proprietary and Confidential Information of Claim Administrator

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If yes, please identify the classes and describe the exclusion: Any retiree with access to Medicare. In the event a pre 65 retiree loses access to Medicare they are able to come back and be insured under this plan.

2. Employee definitions:

Full-Time Employee means:

- ☒ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
- ☐ Other:

Part-Time Employee means:

- ☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
- ☐ Other:

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:

- ☐ The date such person ceases to meet the definition of Eligible Person.
- ☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
- ☐ Other:

4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (the effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).

- ☐ The date of employment.
- ☐ The _____ day of employment.
- ☒ The 1st day of the month following 1 month(s) of employment.
- ☐ The _____ day of the month following _____ days of employment.
- ☐ The _____ day of the month following the date of employment.
- ☐ Other:

Is the waiting period requirement to be waived on initial group enrollment? ☐ Yes ☒ No

Are there multiple new hire waiting periods? ☐ Yes ☒ No

If yes, please attach eligibility and contribution details for each section.

5. Domestic partners covered: ☐ Yes ☒ No

If yes: a domestic partner is eligible to enroll for coverage.

If yes, are domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

If yes, are dependents of domestic partners eligible to enroll for coverage? ☐ Yes ☐ No

If yes, are dependents of domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for domestic partners and/or dependents of domestic partners.

6. Civil Union Partners covered:

- ☒ The Employer is an Illinois county, municipality, the State of Illinois, subject to the Illinois School Code, a church plan or other non-ERISA plan. For such Employers, a Civil Union Partner and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Employer's Plan.

For all other Employers: ☐ Yes ☐ No

If yes: A Civil Union Partner and his or her dependents are eligible to enroll for coverage.

If yes: Are Civil Union Partners and his or her dependents eligible for continuation of coverage? ☐ Yes ☐ No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Civil Union Partners.

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7. **Limiting Age for covered children:** Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

If Employer is an Illinois county, municipality, the State of Illinois, or subject to the Illinois School Code, this Limiting Age is extended to thirty (30) years, for unmarried eligible military personnel as described in the Employer's Plan.

8. **Termination of coverage upon reaching the Limiting Age:**

- ☐ The last day of coverage is the day prior to the birthday.
☒ The last day of coverage is the last day of the month in which the limiting age is reached.
☐ The last day of coverage is the last day of the billing month.
☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the limiting age even if the child continues to be both disabled and dependent on the employee? ☐ Yes ☒ No

However, such coverage shall be extended in accordance with any applicable federal or state law and the Disabled Dependent provisions of this BPA. *The Employer will notify BCBSIL of any instance where the continuation of disabled dependent coverage is required.*

9. **Disabled dependent:** A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse. A child is a disabled child when the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, per Internal Revenue Code Section 22(e)(3).

To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. BCBSIL will administer its standard process for administration of disabled dependent coverage if (a) below is selected by Employer, or at the Employer's direction memorialized below, BCBSIL will follow a customized process if Employer selects (b). If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

- (a) ☒ Disabled dependent administration will follow **Standard Rules**.

A disabled dependent is eligible to **continue** coverage beyond the limiting age, provided the disability began before the child attained the age of 26. A disabled dependent is eligible to **be added to** coverage beyond the limiting age, provided the disability began before the child attained the age of 26, and proof of coverage as a disabled dependent is provided. Administration of certification review is administered by BCBSIL; a disabled dependent certification form must be submitted to BCBSIL.

- (b) ☐ Disabled dependent Administration will follow **Custom Rules**. Please make the following sections:

Age: *Please select one option regarding age of when the disability began.*

- ☐ The disability must have begun before the child attained the age of 26.
☐ All disabled dependents are covered regardless of when the disability began.

Proof of prior coverage: *Please select required or not required below:*

When **adding** coverage, proof of prior coverage as a disabled dependent is ☐ required ☐ not required.

Certification review: *Please select one option regarding the administration of certification review.*

- ☐ Certification review is administered by BCBSIL; a disabled dependent certification form must be submitted to BCBSIL.
☐ Certification review is administered by the Employer; there are no disabled dependent certification form requirements.

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If certification review is administered by BCBSIL, please select one option regarding forms:

- ☐ Utilize BCBSIL disabled dependent certification forms.
☐ Utilize custom/other disabled dependent certification forms.

If Certification Review is administered by BCBSIL, please select allowed or not allowed below:

- A disabled dependent approved certification from a prior insurance carrier is ☐ allowed ☐ not allowed.
A disabled dependent approved certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

10. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

- ☒ Yes (specify number of days below) ☐ No

Temporary Layoff: 365 days

Disability: 365 days

Leave of Absence: 365 days

However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with an applicable federal or state law. The Employer will notify BCBSIL in any instance where an extension of benefits is to be provided due to a temporary layoff, disability, or leave of absence.

11. Enrollment:

Special Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for group coverage assistance under a state Medicaid or CHIP premium assistance program.

Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so, during the Employer's annual Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

Specify Open Enrollment Period: October 1 to October 31 for a January 1st effective date

Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

Select one of the provisions below:

- ☒ Open Enrollment – Late applicants may only apply during Open Enrollment.
☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and the rules governing off-cycle enrollments.

12. * Does COBRA Auto Cancel apply? ☒ Yes ☐ No

Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

** Not recommended for accounts with automated eligibility.*

CURRENT EMPLOYEE ELIGIBILITY INFORMATION

Current number of eligible subscribers at onboarding and/or annual renewal 408.

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Lines of Business (Check all applicable services)	☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS
Medical Plan Services: ☒ Participating Provider Option (PPO) ☐ Blue Choice Select PPO ☐ Blue Choice Options ☐ Blue High Performance Network SM (BlueHPN SM) Additional Services: ☒ Wellbeing Management ☐ Wellness Incentives ☐ Enable ☐ Empower+ ☐ Health Advocacy Solutions ☐ Mercer Health Advantage ☐ Custom Care Management Unit ☐ Blue Directions SM (Private Exchange) <i>(If selected, the Blue Directions Addendum is attached and made a part of the parties' Administrative Services Agreement.)</i> ☐ Limited Fiduciary Services for Claims and Appeals ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other ☐ Other Ancillary Services: ☐ Dental Plan Services ☐ Vision Insurance <i>(if selected, complete a separate application)</i> ☒ Stop Loss <i>(if selected, complete separate Application and Policy Schedule for Stop Loss Coverage)</i> ☒ Critical Illness, Accident, or Hospital Indemnity Insurance <i>(if selected, complete a separate application for those coverages)</i> ☐ COBRA Administrative Services <i>(Please provide name of entity administering COBRA:)</i>	Consumer Driven Health Plan: ☐ BlueEdge SM HCA Administrative Services <i>(if purchased, complete separate HCA BPA)</i> ☐ BlueEdge SM HSA Eligible Health Plan (Integrated Vendor: Select Vendor)* <i>If HealthEquity, Inc. is selected, BCBSIL to send HSA enrollment to HealthEquity, Inc.</i> ☐ Yes ☐ No Non-Integrated Vendor: ☐ FSA (Integrated Vendor: Select Vendor)* Non-Integrated vendor: ☐ HRA (Integrated Vendor: Select Vendor)* Non-Integrated vendor: Prescription Drugs: ☒ Covered under a pharmacy benefit <i>(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)</i> ☐ Covered under the medical benefit or Blue Script Pharmacy Network (Select one): ☐ Traditional Select Network ☒ Advantage Network ☐ Preferred Network (Not offered with Blue Script) ☐ Elite Network (Not offered with Blue Script) ☐ Network on PBM Fee Schedule Addendum ☐ Other (please specify): PPO Drug List: Performance Biosimilar Drug List Other (please specify): PPO/HSA Preventive Drug List: Please specify: Select Option Other Rx programs: Please specify: Select Program Prescription Drug Program Clinical Programs ☐ Pharmacy Care Management (Retrospective) (Included with HAS)

*An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy with respect to HSAs, FSAs, HRAs, or other benefit arrangements does not conflict with current IRS requirements.

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of Illinois.

Custom Care Management Unit is offered by WTW, an independent company, and is administered by Blue Cross and Blue Shield of Illinois.

Medical and Dental benefits and services are administered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Critical Illness, Accident, Hospital Indemnity and Vision products are issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Illinois is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association, BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this Fee Schedule.

Payment Specifications		☐ NO CHANGES		☐ SEE ADDITIONAL PROVISIONS	
Employer Payment Method: ☐ Online Bill Pay ☐ ACH/WIRE ☐ Auto Debit Employer Payment Period: ☐ Daily ☒ Weekly Claim Invoices are due in two (2) business days. Administration fees are due monthly. Run-Off Period: Employer payments are to be made for _____ months following end of Fee Schedule Period. <i>Standard is twelve (12) months.</i> Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: _____ months.					
Administrative Per Employee Per Month (PEPM) Charges		☐ NO CHANGES		☐ SEE ADDITIONAL PROVISIONS	
Administrative Fee	\$70.35	\$	\$	\$	\$
Dental	\$	\$	\$	\$	\$
Claims Fiduciary	\$	\$	\$	\$	\$
Advanced Payment Review	25% \$	% \$	% \$	% \$	% \$
*Medical Drug Rebate Credit	\$(2.20)	\$ ()	\$ ()	\$ ()	\$ ()
*Rebate Credit for the Prescription Drug Program	\$(115.00)	\$ ()	\$ ()	\$ ()	\$ ()
Telehealth (Virtual Visits)	\$	\$	\$	\$	\$
Wellbeing Management	\$	\$	\$	\$	\$
Health Advocacy Solutions	\$	\$	\$	\$	\$
Pharmacy Care Management (Retrospective) (No cost if both HAS and Prescription Drug Program are elected)	\$	\$	\$	\$	\$
Commissions: _____	\$	\$	\$	\$	\$
Commissions: _____	\$	\$	\$	\$	\$
Commissions: _____	\$	\$	\$	\$	\$
Other: Select Service Category List Service:	\$	\$	\$	\$	\$
Other: Select Service Category List Service:	\$	\$	\$	\$	\$
Other: Select Service Category List Service:	\$	\$	\$	\$	\$
Other: Select Service Category List Service:	\$	\$	\$	\$	\$
Miscellaneous:	\$	\$	\$	\$	\$
Miscellaneous:	\$	\$	\$	\$	\$
Miscellaneous:	\$	\$	\$	\$	\$
Total	\$(46.85)	\$	\$	\$	\$

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*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Claim Administrator Provider Access Fee(s)

Group Number(s): 438994

☒ % of ADP Savings: **1.84%**

☐ \$ per Covered Employee per month: \$

☐ **Group with multiple Provider Access Fees by services (e.g., CMM, and/or PPO plans):**

Group Number(s):

☐ % of ADP Savings: %

☐ \$ per Covered Employee per month: \$

BlueCard Program/Network access fees: Available upon request.

Administrative Line Item Charges ☐ SEE ADDITIONAL PROVISIONS		Frequency	Amount
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____		\$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____		\$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____		\$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____		\$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____		\$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____		\$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____		_____%
Total:			\$_____

Proprietary and Confidential Information of Claim Administrator

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Other Service and/or Program Fee(s)☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS****NSA Fees**

In connection with the claims, items, and services that are subject to the No Surprises Act ("NSA") and disputed by a Provider, Employer agrees to pay Claim Administrator all costs imposed by the IDR Entity or CMS, and any State, federal, or local government entity.

As of June 11, 2026, the CMS fee is \$15. The range for IDR Entity Fee is \$200-\$800 for single determinations and \$268-\$1,173 for batched determinations. CMS and IDR Entity Fees are posted on cms.gov and are subject to change. Please note that BCBSIL will apply the CMS fee that is in effect at the time of the IDR initiation. This fee is subject to change by CMS.

External Review Coordination: ☒ Yes ☐ No

If yes, coordination fee: \$700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan.

Employer elects the following process:

☒ State of Illinois External Review Process ☐ Federal Affordable Care Act Process

If no, provide name and address of administrator(s) of external review coordination and indicate if administering medical claims and/or pharmacy claims:

Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address:

Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address:

Advanced Payment Review (APR): ☒ Yes ☐ No

APR is a suite of payment integrity offerings. Refer to the ABS. If Employer elects APR, indicate APR Savings Program or PEPM below:

☒ APR Savings Program
☐ PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program, Claim Administrator will invoice the percentage indicated in the Fee Schedule of any savings amounts identified by Claim Administrator or third-party vendor.

Reimbursement Services: ☒ Yes ☐ No If yes, Claim Administrator will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

FlexAccess™: ☐ Yes ☒ No

As part of its plan design, Employer has directed Claim Administrator to administer claims, copay and coinsurance requirements for Covered Persons enrolled in the FlexAccess program, including (i) adjusting Covered Persons' copayment amounts to the amount of the manufacturer copay assistance, (ii) applying such manufacturer assistance to reduce Covered Persons' out of pocket costs, and (iii) not applying the manufacturer assistance to Covered Persons' deductibles and/or out of pocket maximum accumulators. Employer agrees that FlexAccess is a plan design decision of Employer and is consistent with Employer's plan design and supported by plan documents. Employer further agrees it is solely responsible for, and will hold Claim Administrator harmless from, the legal and regulatory compliance of the Plan and its plan design, to the extent permitted by law.

Claim Administrator will assess a program fee equal to 20% of the total shared savings. Total shared savings is calculated as the difference between Employer responsibility without the FlexAccess Program and Employer responsibility with the FlexAccess Program. The Employer responsibility without the FlexAccess Program is the cost of the drug minus the Covered Person's cost share if the Covered Person was not enrolled in the program. The Employer responsibility with the FlexAccess Program is the cost of the drug minus: (1) the manufacturer copay assistance dollars that are allocated to the cost of the drug and (2) the cost share for the Covered Persons enrolled in the program.

Proprietary and Confidential Information of Claim Administrator

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FLEXACCESS™ QUALIFIED HDHP: ☐ Yes ☒ No

As part of its plan design, Employer has directed Claim Administrator to administer claims, copay and co-insurance requirements for Covered Persons enrolled in FlexAccess Qualified HDHP, including applying such manufacturer copay assistance to reduce Covered Persons' out of pocket costs, and not applying the manufacturer assistance to Covered Persons' deductibles and/or out of pocket maximum accumulators. Employer agrees that FlexAccess Qualified HDHP is a plan design decision of Employer and is consistent with its plan design and supported by the Employer's plan documents. Employer further agrees it is solely responsible for, and will hold Claim Administrator harmless from, the legal and regulatory compliance of the Plan and its plan design, to the extent permitted by law.

Claim Administrator will assess a fee equal to 20% of program savings for administrative fees. Program savings (shared savings) will be calculated based on the manufacturer copay assistance dollars that are allocated to the cost of the drug minus the Covered Persons' estimated cost share (copay or coinsurance) that would have been paid if they were not enrolled in the program.

The difference between Employer Responsibility for claims utilizing FlexAccess Qualified HDHP and not utilizing FlexAccess Qualified HDHP includes as follows:

WITH FLEXACCESS QUALIFIED HDHP: Cost of drug – amount manufacturer copay assistance used – Covered Persons' out-of-pocket cost (if any) up to Deductible... Copay assistance reversed from deductible. Plan pays no portion.

WITHOUT FLEXACCESS QUALIFIED HDHP: Cost of drug – Covered Persons' out-of-pocket cost - Non-FlexAccess Qualified HDHP coupon... Copay assistance applied to Deductible. Plan may pay portion of claim after deductible met

Third-Party Law Firms Provisions (other than Reimbursement Services): Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for covered services under such Arrangements is described in the Administrative Services Agreement between the Claim Administrator and the Employer.

Virtual Visits Program: ☐ Yes ☒ No

If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video or asynchronous message (where available) capability from Virtual Visits powered by MD Live Virtual Care.

MD Live Virtual Care, a separate company, has contracted with Blue Cross and Blue Shield of Illinois to administer the Virtual Visits programs for members of BCBSIL. MD Live Virtual Care and the MD Live Virtual Care logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. This third-party vendor is solely responsible for its operations and contracted providers.

Proprietary and Confidential Information of Claim Administrator

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Termination Administrative Charge

As applies to the Run-Off Period indicated in the Payment Specifications section above:

- i. ***For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination of the Administrative Services Agreement or partial termination of Covered Employees,*** the Termination Administrative Charge will be the amount equal to ten percent (10%) of the annualized charges based on the service charges in effect as of the termination date or date of partial termination and the Plan participation of the two (2) months immediately preceding the termination date or date of partial termination. Such aggregate amount will be due the Claim Administrator within ten (10) days of the Claim Administrator's notification to the Employer of the Termination Administrative Charge described herein.
- ii. ***For service charges (including, but not limited to, access fees) billed on a basis other than per Covered Employee at the time of termination of the Administrative Services Agreement or partial termination of Covered Employees,*** the Termination Administrative Charge will be such service charges in effect at the time of termination of the Administrative Services Agreement or partial termination of Covered Employees to be applied and billed by the Claim Administrator, and paid by the Employer, in the same manner as prior to termination of the Administrative Services Agreement or partial termination of Covered Employees.

Other Provisions

☒ NO CHANGES

☐ SEE ADDITIONAL PROVISIONS

1. Summary of Benefits & Coverage:

- a. Will Claim Administrator create Summary of Benefits and Coverage (SBC)?

☒ Yes. Please answer question b. The SBC Addendum is attached.

☐ No. If no, then skip question b and refer to the Administrative Services Agreement for further information.

- b. Will Claim Administrator distribute the (SBC) to Covered Persons?

☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (or hire a third party to distribute) as required by law.

☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and distribute SBC to Covered Persons via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is one dollar and fifty cents (\$1.50) per package.

2. Massachusetts Health Care Reform Act:

Employer represents it is subject to the Massachusetts Health Care Reform Act's notification and reporting requirements. ☒ Yes ☐ No

If yes, does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☒ Yes ☐ No

Please note Employer will be responsible for conducting or otherwise performing creditable coverage eligibility testing. By electing Claim Administrator to disseminate the above written statements, Employer is representing that any such coverage qualifies as creditable coverage under the applicable Massachusetts Health Care Reform Act requirements.

3. Alternative Care Management Program (applicable to the purchased medical management program):

☒ Yes ☐ No

The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

Proprietary and Confidential Information of Claim Administrator

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4. **Prior Authorization** (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which Prior Authorization (also called pre-notification or preauthorization) is required.

5. **Essential Health Benefits ("EHB") Election:**

Employer elects EHBs based on the following:

1. ☒ EHBs based on a Claim Administrator state benchmark:
☒ Illinois ☐ Montana ☐ New Mexico ☐ Oklahoma ☐ Texas
2. ☐ EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
 If so, indicate the state's benchmark that Employer elects: ____
3. ☐ Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Illinois benchmark plan.

6. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement between the parties with both such documents to be referred to collectively as the "Administrative Services Agreement" unless specified otherwise.

7. **Independent Dispute Resolution Process:**

Employer authorizes and directs Claim Administrator to offer an amount not to exceed the greater of the Qualifying Payment Amount (QPA) or the amount allowed on the initial notice of payment or denial of a claim on behalf of the Employer during negotiations under the federal IDR process.

8. **Medicare Secondary Payer (MSP):**

- a. Under Federal Law, Employers are required to provide accurate employee counts annually during the data collection period through Blue Access for EmployersSM or through a stand-alone MSP form emailed to data_collection@bcbsil.com. This is required even when there has been no change to the employee count provided by the Employer in the previous year. If the Employer does not provide its employee counts during the annual data collection period, the Centers for Medicare and Medicaid Services require that the Employer's group health plan be considered primary to Medicare. Therefore, the failure to provide this information in a timely manner, by submitting annual employee count reports will result in the Employer's group health plan being primary to Medicare and could impact the coverage and benefits your Employer's Medicare-enrolled plan enrollees experience. To the extent CMS imposes civil money penalties on the Claim Administrator as a result of the Employer's inaccurate or untimely reporting of employee counts, the Employer acknowledges and agrees that it is responsible for such civil money penalties and that it is required to reimburse the Claim Administrator for any payments made by the Claim Administrator in connection with any imposed civil money penalties. If our records reflect Medicare as primary payer for working-aged and disabled persons or only disabled persons, the Employer must certify its employee count on an annual basis during the data collection period through Blue Access for EmployersSM or by completing a stand-alone MSP form and emailing it to data_collection@bcbsil.com. If our records reflect Medicare as primary payer for working-aged and disabled persons or only disabled persons, the employer must certify its employee count on an annual basis during the data collection period through Blue Access for EmployersSM or by completing a stand-alone MSP form and emailing it to data_collection@bcbsil.com.
- b. It shall be the Employer's responsibility to provide the Claim Administrator with accurate and complete Social Security Numbers for Medicare eligible members. Employers may be responsible for any civil money penalties imposed against the Claim Administrator as a result of inaccurate or untimely reporting of the required data elements, including complete Social Security Numbers.

Additional Provisions: Effective 1/1/2027: Removing coverage for GLP1's.

Proprietary and Confidential Information of Claim Administrator

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BCBSIL will provide a one-time wellness credit of \$25,000 for the twelve-month period beginning on the Contract Effective Date, to be used to cover costs and expenses associated with implementation and/or operation of a wellness program. If Employer cancels coverage before expiration of the policy period, Employer will be required to refund BCBSIL the full amount of the wellness credit.

Signature

Eugene Blaz

Sales Representative

890630.824.5066

DistrictPhone & FAX Numbers

Beth E. Ishmael

Producer Representative

The Horton Group/MMA

Producer Firm

10320 Orland Parkway, Orland Park, IL

Producer Address

708-845-3112

Producer Phone & FAX Numbers

beth.ishmael@thehortongroup.com

Producer Email Address

36-3672171

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until either revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

☐ Intentionally left blank by the Employer

Group No.: 438994 By: _____

 Print Signer's Name Here
 ➡ _____
 Signature and Title

Group Name: Village of Downers Grove

Address: 850 Curtiss Street

City: Downers Grove State: IL ZIP: 60515

Dated this _____ day of _____

 Month Year

Proprietary and Confidential Information of Claim Administrator

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IL GEN ASO BPA (Rev. 06.26) *Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association*

Exhibit X for PPO Traditional Self-Funded Account Contract

Only the BlueCard Program Access Fee will be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in the General Administrative Fee.

The Access Fee is charged by the Host Blue to Claim Administrator for making its applicable provider network available to Employer's Covered Persons. The Access Fee will not apply to nonparticipating provider claims. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential Claim Administrator receives from the applicable Host Blue subject to a maximum of \$2,000 per claim. When charged, Claim Administrator passes the Access Fee directly on to Employer.

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

A General Administrative Fee encompasses fees Claim Administrator charge to Employer for administering Employer's benefit plan. They may include both local within Claim Administrator's service area and Inter-Plan fees. For purposes of this agreement, they include the following BlueCard Program-related fees other than the BlueCard Program Access Fee: namely, Administrative Expense Allowance (AEA) Fee, Central Financial Agency Fee, ITS Transaction Fee and Blue Cross Blue Shield Global® Solutions Fees, if applicable.

Purchaser Name: See BPA
Purchaser Base Number(s): See BPA
Effective Date: (Contract Year) of this Exhibit X: See BPA

Inter-Plan Program Fees:	
BlueCard Program Fees:	
Access Fees:	3.11% (in 2027 for fewer than 1,000 PPO or traditional enrolled Blue contracts); 1.73% (in 2027 for 1,000–9,999 Blue PPO enrolled contracts); or 1.61% (in 2027 for 10,000–49,999 Blue PPO enrolled contracts) of network savings, capped at \$2,000.00 per claim.
General Administrative Fee:	See BPA

PBM Fee Schedule Addendum to the Benefit Program Application

Village of Downers Grove	
Term:	01/01/2027 - 12/31/2027
Employees: 408	
Guaranteed Traditional Aggregate Pricing Arrangement D ^{1*} Advantage Network and Performance Biosimilar Drug List	
RETAIL	
Brand	Generic
AWP minus	AWP minus
20.75%	84.60%
DISPENSING FEE	
Brand	Generic
\$0.45	\$0.45
MAIL	
Brand	Generic
AWP minus	AWP minus
23.25%	86.40%
DISPENSING FEE:	
\$0.00	
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	Generic
AWP minus	AWP minus
23.25%	86.40%
DISPENSING FEE:	
\$0.00	
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 21.75%
DISPENSING FEE:	
\$0.00	
Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	\$115.00
Employer Administration Fees:	
PBM Administration Fees PEPM:	\$0.00
Consulting Fee/Commission:	\$0.00 Please select

Additional Provisions:

¹ Employer will be billed for retail brand and retail generic prescriptions, mail brand and mail generic prescriptions, ESN brand and ESN generic, and Specialty pharmacy claims (excluding compound prescriptions) based on the lesser of (a) U&C or (b) PBM’s adjudication rate schedule(s) that is/are intended to achieve, on an aggregate calendar-year basis, the AWP discounts and Dispensing Fees shown above for all of Claim Administrator’s group customers that have purchased the above specific pricing arrangement (“Groups with the Pricing Arrangement”) and use the above Network (the “Employer’s Contract Rates”).

For purposes of setting Employer’s Contract Rates and calculating whether the AWP discounts and Dispensing Fees have been achieved:

- a. Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to “M”, “N”, or “O”.
- b. Generic drugs are defined as all drugs available in sufficient supply that have a Medi-Span multisource code field equal to “Y”.

Employer acknowledges and agrees that Employer’s Contract Rates may vary based on market influences and as necessary to achieve the AWP discounts and Dispensing Fees shown above, on an aggregate calendar year basis, for Groups with the Pricing Arrangement that use the above Network. However, such variation for Brand products in each of the Retail, Mail, and ESN categories (on an aggregate annual basis) may only vary by +/-1.5% from the applicable AWP discount shown above.

Employer will be billed the above Dispensing Fee (such Fee may be included in the amount billed to Employer) unless the Employer is billed based on the U&C price. If the Employer is billed based on the U&C price, then the Dispensing Fee is included in such U&C price.

Employer will be billed for Compound Drug claims based on the applicable discounted rate in the Network Contract.

Employer will be billed for Foreign Claims based on an amount equal to the amount billed by the pharmacy.

Employer will be billed for out-of-network claims based on the pricing set forth in the Administrative Services Agreement and/or PBM Exhibit, as applicable.

If the AWP discounts and Dispensing Fees shown above are not achieved for a particular calendar year, for Groups with the Pricing Arrangement that use the above Network, then Employer will be credited, 120 days after the end of each calendar year during the Term, an amount calculated as follows:

- First, the total aggregate shortfall dollar amount for the calendar year for Groups with the Pricing Arrangement that use the above Network will be calculated by comparing the actual performance of each of the above categories (Retail, Mail, ESN, and Specialty) with the corresponding AWP discounts and Dispensing Fees shown above for each category. The amount of any performance in any category that exceeds the above AWP discounts and Dispensing Fees will be used to offset any and all shortfall(s) in any or all categories. The above aggregate shortfall, if any, is then divided by total claims for Groups with the Pricing Arrangement that use the above Network, and did not terminate their Addendum prior to their anniversary date, for the calendar year (“Per Claim Amount”). Then the Per Claim Amount will be multiplied by Employer’s total claims for that calendar year to calculate the reconciliation credit. However, if Employer terminates this Addendum prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Employer will not be eligible to receive such credit.
- For purposes of determining if a shortfall exists, claims billed to Employer based on the U&C price will be considered to have \$0.00 Dispensing Fees.
- Compound Drug, Foreign, reversed, member submitted, long term care (LTC), home infusion, veterans affairs, Indian/Tribal/Urban pharmacy, 340B eligible, Medicare/Medicaid, coordination of benefits (COB), subrogation, paper, invalid, usual and customary (U&C), Direct Member Submitted, Covid related, and out-of-network claims are excluded from the calculation of whether the AWP discounts and Dispensing Fees shown above have been achieved and also are excluded from the calculation of any shortfall credit for Employer.
- Products with government mandated reimbursement, emergency use protocols, or related to Covid-19 (e.g. testing, vaccines, and treatments) are excluded from guarantee reconciliation.
- Non-specialty discount and dispensing fees also exclude specialty (as defined by the BCBS specialty drug pricing file).

HCSC GEN ASO Traditional PBM Fee Addendum 6.19

- If the AWP discounts and Dispensing Fees shown above are exceeded for Groups with the Pricing Arrangement that use the above Network, then Employer will not receive any credit, and there will not be a year-end settlement.
- Under the Guaranteed Traditional Aggregate Pricing Arrangement any particular group customer’s experience relative to the pricing guarantees will not determine its eligibility for a credit. Group customer’s eligibility for a credit is determined based on the aggregate experience of all group customers that have purchased the Pricing Arrangement and use the above Network. As such, an individual group customer may have experience that does not meet, or exceeds, the AWP discounts and Dispensing Fees shown above. In addition, when there is a reconciliation credit, it is allocated in a manner described above and not based on any particular group’s experience (other than number of claims).
- MedsYourWay program claims will be included in calculation of the discount and Dispensing Fee pricing guarantees. MedsYourWay is the embedded drug discount card comparison program utilized where available and applicable to Employer, Network Pharmacy, and the Covered Drug

PBM uses Medi-Span as the pricing source to establish AWP, for purposes of calculating whether the above AWP discounts have been achieved.

Members’ cost share is the applicable copayment, deductible, and/or coinsurance, which coinsurance is calculated based on the Employer’s Contract Rate or the applicable out-of-network pricing. Zero balance logic is not employed.

AWP discounts are based on the actual NDC-11 dispensed.

AWP discounts do not include savings from drug utilization review or other clinical or medical management programs.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees may be subject to change if the Employer’s claims include 340B pricing.

In addition to the rights of the parties under the PBM Exhibit, if changes occur within the pharmacy benefit management marketplace which lead to a significant deviation from the current economic environment, both parties agree to engage in good faith negotiations to amend this Addendum to make impact on both parties commercially reasonably economically neutral. If the parties cannot agree on the terms of the amendment, either party shall be allowed to (a) proceed to dispute resolution, as set forth in the Administrative Services Agreement or (b) terminate this Addendum with 90 days’ prior written notice to the other party. Failure to reach agreement on the amendment shall not be a breach of contract.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees are based on the Network and Drug List shown above.

Unless otherwise specified in this Addendum, capitalized terms used in this Addendum shall have the meanings set forth in the Administrative Services Agreement or the PBM Exhibit, as applicable.

Aggregate Specialty Discount and Dispensing Fee guarantees include limited distribution drugs (LDD) and new to market specialty drugs.

* Employer Payments to Claim Administrator for Covered Services provided by Network Participants are calculated based on the pricing terms set forth in this Addendum which shall remain in effect for the term of this Addendum to the extent described in the Administrative Services Agreement. Such pricing may or may not equal the amounts actually paid to the Network Participants or received from drug manufacturers (e.g., rebates), or the amounts paid or received between Claim Administrator and the PBM. As a result, the PBM or Claim Administrator may realize positive margin on prescriptions filled at retail, mail order, ESN or specialty pharmacies or prescription drug rebates. Employer acknowledges that it has negotiated for the specific traditional pricing terms set forth in this Addendum, and that it and its group health plan have no right to, or legal interest in, any portion of any positive margin retained by Claim Administrator or PBM and consents to Claim Administrator’s and PBM’s retention of all such amounts.

Signature of Authorized Purchaser

Print Name

Title

Date

PBM Rebate Fee Schedule Addendum to the Benefit Program Application for Plan year 2027

Employer Name	Village of Downers Grove	Employees: 408
Term:	01/01/2027 – 12/31/2027	

Rebates to Employer With Basic Drug List*:			
Per Retail Brand Drug Dispensed: \$162.20	Per ESN Brand Drug Dispensed: \$354.90	Per Mail Brand Drug Dispensed: \$354.90	Per Specialty Brand Drug Dispensed: \$1,933.10
Rebates to Employer With Enhanced Drug List*:			
Per Retail Brand Drug Dispensed: \$143.30	Per ESN Brand Drug Dispensed: \$313.50	Per Mail Brand Drug Dispensed: \$313.50	Per Specialty Brand Drug Dispensed: \$1,707.40
Rebates to Employer With Performance Biosimilar Drug List*:			
Per Retail Brand Drug Dispensed: \$193.10	Per ESN Brand Drug Dispensed: \$422.50	Per Mail Brand Drug Dispensed: \$422.50	Per Specialty Brand Drug Dispensed: \$1,455.60
Rebates to Employer With Balanced Biosimilar Drug List*:			
Per Retail Brand Drug Dispensed: \$217.90	Per ESN Brand Drug Dispensed: \$476.80	Per Mail Brand Drug Dispensed: \$476.80	Per Specialty Brand Drug Dispensed: \$1,642.80
Rebates to Employer With Performance Select Biosimilar Drug List*:			
Per Retail Brand Drug Dispensed: \$221.60	Per ESN Brand Drug Dispensed: \$485.00	Per Mail Brand Drug Dispensed: \$485.00	Per Specialty Brand Drug Dispensed: \$1,671.60

*Refer to Lines of Business Section of the Benefit Program Application ("BPA") to determine selected Drug List.

Additional Provisions:

- Guaranteed offer is based on adoption of the specified drug list above indicated in the BPA. In the event there is a change in or drug list, implementation of new clinical programs, changes to the pharmacy benefit plan design, lock-out of drug classes, or unexpected generic launches, both parties agree to engage in good faith negotiations to amend this Addendum to make impact on both parties commercially reasonably economically neutral. If the parties cannot agree on the terms of the amendment, either party shall be allowed to (a) proceed to dispute resolution, as set forth in the Administrative Services Agreement, or (b) terminate this Addendum with 90 days' prior written notice to the other party. Failure to reach agreement on the amendment shall not be a breach of contract.
- The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees may be subject to change if the Employer's claims include 340B pricing.
- Compound, long term care (LTC), home infusion (HIF), veterans affairs (VA), Indian/Tribal/Urban (I/T/U), 340b eligible, Medicare/Medicaid, HIV PrEP, out of network, member-submitted, foreign, coordination of benefits (COB), 100% member-paid plan (i.e. discount card), subrogation, paper, invalid quantity/unit cost, vaccines, covid related, and over-the-counter (OTC) claims are excluded from rebate guarantees.
- In addition to the rights of the parties under the PBM Exhibit, in the event that any law, regulation, interpretation of a law or regulation, or any changes occur within the pharmacy benefit management marketplace would lead to a significant deviation from the current economic environment, both parties agree to engage in good faith negotiations to amend this Addendum to make impact on both parties commercially reasonably economically neutral. If the parties cannot agree on the terms of the amendment, either party shall be allowed to (a) proceed to dispute resolution, as set

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forth in the Administrative Services Agreement, or (b) terminate this Addendum with 90 days’ prior written notice to the other party. Failure to reach agreement on the amendment shall not be a breach of contract.

- Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to “M”, “N”, or “O”.
- Generic drugs are defined as all drugs that have a Medi-Span multisource code field equal to “Y”.
- Notwithstanding the methodology for calculating discount and dispensing fee guarantees set forth above, the Per Brand Script Minimum Rebate guarantees are strictly applicable to Employer’s claims utilization and performance experience.
- Unless otherwise specified in this Addendum, capitalized terms used in this Addendum shall have the meanings set forth in the Administrative Services Agreement or the PBM Exhibit, as applicable.
- Rebates will be reconciled annually to the greater of the Per Brand Script Minimum Rebate guarantees or PEPM Rebate credit.
- Pricing assumptions for Basic and Enhanced drug lists are 65% Humira, 35% Low WAC Brand and 0% Low WAC Generic.
- Pricing assumptions for Basic and Enhanced drug lists are 66% Stelara, 34% Low WAC Brand and 0% Low WAC Generic.
- Pricing assumptions for Performance Biosimilar, Balanced Biosimilar and Performance Select Biosimilar drug lists are 6% Humira, 94% Low WAC Brand, and 0% Low WAC Generic
- Pricing assumptions for Performance Biosimilar, Balanced Biosimilar and Performance Select Biosimilar drug lists are 5% Stelara, 95% Low WAC Brand, and 0% Low WAC Generic.
- Rebate guarantees are inclusive of and assume WAC reduction effective 02/01/2026. Claim Administrator reserves the right to adjust the reconciliation of guarantees for any other products with a WAC decrease.
- Non-Diabetic GLP-1 Medications are not factored into the rebate projections.

Signature of Authorized Purchaser

Print Name

Title

Date