BlueCross BlueShield of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

(All items are applicable to 151-Plus Grandfathered and Non-Grandfathered Insured Group Accounts unless otherwise specified.)
(All items are applicable to the HMO plan and the Non-HMO plan unless otherwise specified.)

Employer Account Number: 010156
HMO Illinois Employer Group Number(s): H10156
HMO Illinois Section Number(s): See Acct Structure
BlueAdvantage® HMO Employer Group Number(s): B10156
BlueAdvantage® HMO Section Number(s): See Acct Structure
Non-HMO Plan Employer Group Number(s): PC1286
Non-HMO Plan Section Number(s): See Acct Structure

Employer' Legal Name: Village of Oak Park
(Specify the employer, the employee trust or the association applying for coverage. List subsidiary or affiliated companies to be covered below. An employee benefit plan may not be named.)

Physical Address: 123 Madison City: Oak Park State: IL Zip Code: 60302
Billing Address (if different from above): _____ City: _____ State: _____ Zip Code: _____
Employer Identification Number ("EIN"): 36-6006027
Wholly Owned Subsidiaries to be Covered: _____
Affiliated Companies to be Covered: _____

(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.)

Administrative Contact: Kira Tchang Phone: 708-358-5652 Fax: _____ Email: Ktchang@oak-park.us

Blue Access for Employers ("BAE") Contact: Kira Tchang
(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: HR Director Phone: 708-358-5652 Fax: _____ Email: Ktchang@oak-park.us

Policy Effective Date: 01/01/2020 Policy Anniversary Date: 01 / 01 / 2021
Month Day Year

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA provisions except for governmental entities, such as municipalities and public school districts, and "church plans" as defined by the Internal Revenue Code.

ERISA Regulated Group Health Plan*: Yes ☐ No ☒
If **Yes**, specify ERISA Plan Year*: Beginning Date: ___/___/___ End Date: ___/___/___ (month/day/year)

ERISA Plan Sponsor*: _____
ERISA Plan Administrator*: _____
ERISA Plan Administrator's Address: _____
City: _____ State: _____ Zip Code: _____
ERISA Plan Administrator's Email: _____

Please provide your Non-ERISA Plan Month/Year: ___/___

If you contend ERISA is inapplicable to your group health plan, please give legal reason for exemption*:

- ☐ Federal Governmental Plan (e.g., the government of the United States or agency of the United States)
- ☒ Non-Federal Governmental Plan (e.g., the government of the State, an agency of the State, or the government of a political subdivision, such as a county or agency of the State)
- ☐ Church Plan (complete and attach a Medical Loss Ratio Assurance form)
- ☐ Other, please specify: _____

For more information regarding ERISA, contact your Legal Advisor.
*All as defined by ERISA and/or other applicable law/regulations.

ELIGIBILITY

1. Eligible Person:

Employer has decided that Eligible Person means: (For the HMO plan, an eligible person must reside in the Service Area of a Participating IPA.)

- ☒ A Full-Time Employee of the Employer.
- ☐ A Full-Time Employee who is a member of: _____ (name of union or association).
- ☒ Other (please specify): Retirees; Policeman and Firemen must be at least age 50 with 20 years of serivce. Regular full-time employees must be at least 55 years of age with at least 8 years of service for tier one IMRF employees and 10 years of service for tier two IMRF employees.

Full-Time Employee means:

- ☒ An Employee of the Employer who is regularly scheduled to work a minimum of 30 hours per week
- ☐ Other (please specify): _____
- ☐ An Eligible Person may also include a retiree of the Employer. Please specify: _____.

The term "Employee" shall have the meaning set forth under ERISA and applicable law. HCSC reserve the right to audit Employer's initial and ongoing eligibility determinations.

2. Civil Union Partner Coverage:

A Civil Union partner, as defined in the Policy, and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Certificate Booklet. The Employer as Policyholder is responsible for providing notice of possible tax implications to those Insureds with coverage for Civil Union partners.

3. Domestic Partner Coverage: ☐ Yes ☒ No

If Employer elects "**Yes**", a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner Coverage.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but Employer may elect to offer continuation coverage to Domestic Partners similar to that available to spouses under COBRA continuation.

Domestic Partner Coverage Continuation (only available if Domestic Partners are covered) ☐ Yes ☒ No

4. **The Limiting Age for covered children:**

Hereafter, covered children means a natural child, a stepchild, an eligible foster child, an adopted child (including a child involved in a suit for adoption), a child for whom the Insured is the legal guardian, under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under the Policy), marital status, or any combination of those factors. Unless Policyholder elects a Limiting Age over twenty-six (26), coverage will terminate at the end of the month in which the covered child turns age twenty-six (26). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

To cover children age twenty-six (26) or over, you may select option (a) or (b) below:

(a) ☐ Limiting Age for covered children age twenty-six (26) or over, ☐ who are married ☐ who are unmarried ☐ regardless of marital status, is _____ years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

(b) ☐ Limiting Age for covered children who are full-time students and age twenty-six (26) or over, ☐ who are married ☐ who unmarried ☐ regardless of marital status, is _____ years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

For a covered child who reaches a Limiting Age over twenty-six (26), coverage will terminate at the end of the period for which premium has been accepted. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

5. **Eligibility Date:** All current and new employees must satisfy the substantive eligibility criteria and required waiting period indicated below before coverage will become effective. No waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an employee becomes eligible for coverage, unless otherwise permitted by applicable law.

   If a person is added to the Policy and it is later determined that the Policyholder reported a Coverage Date earlier than what would apply to the Employee or dependent, based on the Waiting Period and eligibility conditions the Policyholder provided to the Plan, the Plan reserves the right to retroactively adjust the Coverage Date for such person.

   ☒ The date of employment.
   ☐ The _____ day of employment. **Note:** This may not exceed ninety-one (91) calendar days.
   ☐ The _____ day (select 1st or 15th) of the month following _____ month(s) (option of 1 or 2 months) of employment.
   ☐ The _____ day (select 1st or 15th) of the month following _____ days (option of up to 60 days) of employment.
   ☐ The _____ day of the month following the date of employment.
   ☐ Other (please specify): _____. **Note:** This may not exceed ninety-one (91) calendar days.
   ☒ This election applies only to the HMO plan: A full month's premium will be charged for the first (1st) month of coverage for those employees whose Coverage Dates fall between the first (1st) and fifteenth (15th) day of the Premium period. No premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the sixteenth (16th) day and the end of the Premium Period.

   Substantive eligibility criteria.
   Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, Employer is required to submit a new BPA to reflect that new information.

   Check all that apply:
   ☐ An Orientation Period that:
      1) Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and
      2) If used in conjunction with a waiting period, the waiting period begins on the first day after the orientation period.
   ☐ A Cumulative hours of service requirement that does not exceed 1200 hours
   ☒ An hours-of-service per period (or full-time status) requirement for which a Measurement period is used to determine the status of variable-hour employees, where the measurement period:
      1) Starts between the employee's date of hire and the first day of the following month;
      2) Does not exceed 12 months; and
      3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).
   ☐ Other substantive eligibility criteria not described above; please describe: _____

6. **Special Enrollment**: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and /or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage. In the case of a Special Enrollment event due to loss of coverage under Medicaid or a state children's health insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

   This election applies only to the Non-HMO plan: Annual Open Enrollment: ☒ Yes ☐ No

   Annual Open Enrollment: Specify Annual Open Enrollment Period:October 1st for a January 1st effective date.. 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 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 Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer. Such date shall be subsequent to the annual open enrollment period.

7. **This Section applies only to the HMO plan**: The Effective Date of Termination for a person who ceases to meet the definition of an Eligible Person:

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

☐ Other (please specify): _____.

8. **Extension of benefits due to Temporary Layoff, Disability or Leave of Absence**:

Temporary Layoff: 0 days Disability: 365 days Leave of Absence: 365 days

☐ Other: (please specify): _____

However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.

In the event of Total Disability at the time the group policy is terminated, an Extension of Benefits will be provided for a period of no more than twelve (12) months from the date of termination, to the extent required, and in accordance, with any applicable federal or state law.

9. **For the HMO Plan**:

Total Number of Employees (Please indicate the total number of actual employees, not enrollees):

Of the Employer: 388 Illinois employees: 388 National employees: 0

10. **FUNDING ARRANGEMENT:** ☐ Standard Premium – Prospective ☒ Cost Plus Program

11. **STANDARD PREMIUM INFORMATION:**

The following elections apply to both Grandfathered and Non-Grandfathered Groups:

Premium Period:

☐ The first (1st) day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare® Dental HMO coverage.)

☐ The _____ day of each calendar month through the _____ day of the next calendar month. (This option is not available for any coverage if the Employer has BlueCare Dental HMO coverage.)

12. **MINIMUM PARTICIPATION AND EMPLOYER CONTRIBUTION INFORMATION:**

(a) **The following elections apply to both Grandfathered and Non-Grandfathered Groups:**

Employer contribution:

☐ One hundred percent (100%) of the Individual Coverage Premium and an amount equal to one hundred percent (100%) of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.

☒ 80% of the Individual Coverage Premium and 80% of the Family Coverage Premium.

☐ Other (please specify): _____.

(b) **The following applies to both Grandfathered and Non-Grandfathered Groups:**
HCSC reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty-five percent (25%) or more over a ninety (90) day period.

(c) **The following applies to Non-Grandfathered Groups:**
HCSC reserves the right to take any or all of the following actions: 1) initial rates will be finalized for the effective date of the policy based on the enrolled participation and employer contribution levels; 2) after the policy effective date the group will be required to maintain a minimum Employer contribution of 25%, and at least a 70% participation of eligible employees (less valid waivers). In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or 3) non-renew or discontinue coverage unless the 25% minimum employer contribution is met and at least 70% of eligible employees (less valid waivers) have enrolled for coverage. Employer will promptly notify HCSC of any change in participation and Employer contribution.

(d) **The following applies to Grandfathered Groups:**
It is understood that no Policy will be issued or renewed on a contributory basis unless at least 25% of the Eligible Persons, and for Family Coverage 75% of the Eligible Persons with eligible dependents, have enrolled for coverage.

13. **Essential Health Benefits ("EHB") Definition Election:**
Employer elects EHBs based on the following:

1. ☒ EHBs based on a HCSC state benchmark:
   ☒ Illinois ("IL") ☐ Oklahoma ("OK") ☐ Montana ("MT") ☐ Texas ("TX") ☐ New Mexico ("NM")
2. ☐ EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

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

STANDARD PREMIUM RATES ☐ Yes ☒ No						
	For Internal Use Only - BlueStar Ben.Agree#: _____ _____	*For Internal Use Only - BlueStar Ben.Agree#:* _____ _____	*For Internal Use Only - BlueStar Ben.Agree#:* _____ _____	*For Internal Use Only - BlueStar Ben.Agree#:* _____ _____	*For Internal Use Only - BlueStar Ben.Agree#:* _____ _____	**Total**
1. Employee only:	$_____	$_____	$_____	$_____	$_____	$_____
2. Employee plus one Dependent (i.e. Employee plus one spouse or one child):	$_____	$_____	$_____	$_____	$_____	$_____
3. Employee plus two or more Dependents:	$_____	$_____	$_____	$_____	$_____	$_____
4. Employee plus Spouse:	$_____	$_____	$_____	$_____	$_____	$_____
5. Employee plus Child(ren) (i.e. Employee plus one or more children):	$_____	$_____	$_____	$_____	$_____	$_____
6. Employee plus Family / Family:	$_____	$_____	$_____	$_____	$_____	$_____
7. Other: _____	$_____	$_____	$_____	$_____	$_____	$_____
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$_____	$_____	$_____	$_____	$_____	$_____
Family Coverage:	$_____	$_____	$_____	$_____	$_____	$_____

COST PLUS PROGRAM
☒ **Yes** ☐ **No**

Service Charges:

For the HMO Plan:

a) Service Charges for Claim Payments:
- ☒ HMO Illinois: _____% of Claim Payments; or $52.69 per Enrollee per month for health Claim Payments.
- ☒ BlueAdvantage® HMO: _____% of Claim Payments; or $52.69 per Enrollee per month for health Claim Payments.

b) Physician's Services Fees:
- ☒ HMO Illinois: $154.22 per month per single Enrollee; or $423.45 per Month per Enrollee with one or more dependents.
- ☒ BlueAdvantage® HMO: $137.39 Per month per single Enrollee; or $381.95 Per Month per Enrollee with one or more dependents.

c) ☒ HMO Managed Care Fee: $10.86 per HMO enrollee per month.

For the Non-HMO Plan:
- ☒ _____% of Net Claim Payments or $52.69 per employee per month.
- ☒ Applies to all coverage(s).
- ☐ Different percentage(s) or amount(s) for the following types of coverage. Please specify below:

For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month.

For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month.

Other (please specify): _____.

☐ Virtual Visits Program (Non-HMO Plan only) ☐ Fee: $_____ per covered employee per month for administration of the program.

☐ Fee is included in the Service Charges.

Ancillary Program:

☐ Health Dialog **(may select one)** Health Dialog Fee: **$**_____ per covered employee per month
- ☐ Health Coach Line (In bound)
- ☐ Health Coach Line (In and out bound)
- ☐ Health Coach Line (With Disease Management)
- ☐ Not applicable

☐ American Healthways **(may select one)**
- ☐ Package A
- ☐ Package B
- ☐ Package C
- ☐ Not applicable

American Healthways Program Fees, per participating Covered Person per month:

Conditions:	Package A - Fees	Package B - Fees	Package C - Fees
Diabetes:	$_____	$_____	$_____
Chronic Heart Disease:	$_____	$_____	$_____
Chronic Obstructive Pulmonary Disease	$_____	$_____	Not Applicable
Asthma:	$_____	$_____	Not Applicable
Impact Conditions:	$_____	Not Applicable	Not Applicable

Payment Method: ☐ Transfer Payment ☐ Post Payment

If Transfer Payment, Method of Transfer Payment:
☒ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer ☐ Other (please specify):_____

Payment Period:
☐ Daily ☐ Weekly ☐ Bi-Weekly ☒ Monthly ☐ Other (please specify): _____

Claim Settlement Period: ☒ Monthly ☐ Quarterly ☐ Other (please specify): _____

If Transfer Payment, Tentative Final Settlement Period:
Transfer Payments to be made for the following time period after termination:
☒ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

Excess Loss – Run Off Period: 12 Months
Standard is twelve (12) months.

Final Settlement: Final Settlement is to be made within 60 days after end of Excess Loss Run-Off Period.
Standard is sixty (60) days.

Employer Payments are to be made past the run-off period for all claims and adjustments.

For Cost Plus plans, 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 (please specify): _____

Prescription Drug Program:
☒ HMO (If selected, the Pharmacy Benefit Manager(s) ("PBM") Fee Schedule Exhibit must be attached and is part of this BPA.)
☒ PPO (If selected, the PBM Fee Schedule Exhibit must be attached and is part of this BPA.)

Rebate Credit for Drugs covered under the Pharmacy Benefit:
PPO: $45.89 per Covered Employee per month
HMO: $45.89 per Enrollee per month

HMO Pharmacy Network (Select one):
☒ Traditional Select Network
☐ Network shown on PBM Fee Schedule Exhibit

PPO Pharmacy Network (Select one):
☒ Advantage Network
☐ Preferred Network
☐ Network shown on PBM Fee Schedule Exhibit

PPO Drug List: [Enhanced Drug List]; **Other (please specify):** HMO Drug List - Performance

Prescription Drug Program Clinical Management Programs

☐ Medication Therapy Management (MTM) (Retrospective) (HMO) ☐ Fee: $_____ per member per month for administration of the program.
☐ Medication Therapy Management (MTM) (Retrospective) (PPO) ☐ Fee: $_____ per member per month for administration of the program.

Termination Administrative Charge

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

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 Policy 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 Policy participation of the two (2) months immediately preceding the termination date or date of partial termination. Such aggregate amount will be due the Plan within ten (10) days of the Plan's notification to the Policyholder 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 Policy or partial termination of Covered Employees,*** the Termination Administrative Charge will be such service charges in effect at the time of termination of the Policy or partial termination of Covered Employees to be applied and billed by the Plan, and paid by the Policyholder, in the same manner as prior to termination of the Policy or partial termination of Covered Employees.

Termination Administrative Charges assume the continuation of the Policy benefit program(s) and the administrative services in effect prior to termination. Should such Policy benefit program(s) and/or administrative services change, or in the event the average Policy enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, the Plan reserves the right to adjust the rates for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge.

FOR NON-HMO COST-PLUS PROGRAMS ONLY:

PLAN PROVIDER ACCESS FEE(S)

☒ **Yes** ☐ **No**

Group Number(s): PC1286

☒% of ADP Savings: 2.33%

☐ $ Per Employee per Month: $_____

Please complete for groups with multiple products (for example, Comprehensive Major Medical and PPO) with separate access fees:

Group Number(s): _____

☐% of ADP Savings: _____%

☐ $ Per Employee per Month: $_____

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this BPA and, on behalf of the Employer, offers to purchase the benefit program as outlined in the Request For Proposal ("RFP") or, in the case of an HMO Plan, the proposal document submitted to the Employer by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Policy. This BPA is subject to acceptance by HCSC. Upon acceptance, HCSC shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Policy, the provisions of the Policy shall prevail. No coverage will begin until receipt of the first (1st) premium by HCSC.

The undersigned representative acknowledges that any producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the producer by HCSC in connection with the issuance of a Policy, the Employer should contact its producer.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Employer (or, for Non-HMO Plans, any group member if the group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC.

The Rebate Credit is a per Covered Employee per month (or, for the HMO plan, per Enrollee per month) credit applied to the monthly billing statement. Rebate Credits shall not continue after termination of the Prescription Drug Program, except as otherwise set forth in this BPA or the PBM Fee Schedule Exhibit. (Further information about rebates, the Pharmacy Benefit Manager and the Rebate Credit is included in the governing Group Administration Document to which this BPA is attached under the section titled "The Plan's Separate Financial Arrangements Regarding Prescription Drugs.").

OTHER PROVISIONS:

(a) **Reimbursement**: It is understood and agreed that in the event BCBSIL makes a recovery on a third-party liability claim, BCBSIL will retain twenty five (25%) of any recovered amounts, other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

(b) **Third Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services)**: Employer will pay no more than 25% of any recovered amount made by the BCBSIL's Third Party Recovery Vendor or up to 25% of any recovered amount will be deducted from the amount distributed according to established allocation processes. Employer will pay no more than 35% of any recovered amount made by BCBSIL'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.

(c) **Summary of Benefits and Coverage ("SBC")**: The SBC Addendum is attached and made a part of the Policy. BCBSIL will create the SBC (only for benefits BCBSIL insures under the Policy) and provide the SBC to the Policyholder in electronic format. If the Policyholder approves of the content, Policyholder will then distribute the SBC to participants and beneficiaries (or hire a third party to distribute) as required by law. If the Policyholder would like changes to the SBC, it will promptly notify BCBSIL. BCBSIL will also distribute the SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Policyholder.

(d) **BlueEdge FSA (Vendor: Select Vendor) purchased**: ☐ Yes ☒ No

(e) **BlueCare® Dental HMO Coverage purchased**: ☐ Yes ☒ No (If yes, complete separate application.)

(f) **Life or Disability purchased**: ☐ Yes ☒ No (If yes, complete separate application.)

(g) **Excess Loss Coverage purchased**: ☒ Yes ☐ No (If yes, complete separate application.)

(h) **Blue Directions for Large Business purchased**: ☐ Yes ☒ No (if yes, The Blue Directions Addendum is attached and made a part of the Policy.)

(i) **For the Non-HMO Plan**:
Case Management: ☒ Yes ☐ No
If Yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Policy.

(j) **Electronic Issuance**: The Employer consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet and SBC provided by BCBSIL to the Employer for delivery to each Employee. The Employer further agrees that it is solely responsible for providing each Employee access, to the most current version of any E-file Certificate Booklet, SBC, amendment, or other revised form provided by BCBSIL, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and hold BCBSIL harmless from any misuse of the E-file provided by BCBSIL. HMO members will continue to receive paper copies of their HMO certificates. By providing your consent, you agree to the electronic delivery of your insurance documents. You can go back to paper delivery at any time with no penalty. Your consent will be valid until it is withdrawn up to and including through policy renewals. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports most versions of Internet Explorer, Chrome and Firefox.

☒ **Accept** – Employer consents to receive electronic versions of Certificate Booklets and SBC's for covered Employees. Employer may withdraw this consent at any time and request receipt of hard copy versions by contacting their BCBSIL Account Executive.

☐ **Decline** – Employer does not consent to receive electronic versions of Certificate Booklets and SBC's for covered Employees or the Contract and desires BCBSIL to print and distribute hard copy versions.

Authorized Company Official's Initials: _____ Date: _____

(k) **Massachusetts Health Care Reform Act:** Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

(l) ☒ **Wellbeing Management:** The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Policy.

Blue Care Connection® ("BCC") Program (For the Non-HMO Plan):

BCC Package (may select one):

☐ Standard
☐ Enhanced
☐ Unbundled
☐ Selective In/Out
☐ Unique Package Design
☐ Stand-Alone

☐ Fee: **$**_____ per covered employee per month for administration of the program.
☐ Fee is included in the Premium Charge/Service Charge

BCC Package Upgrade(s):

☐ Description: _____
☐ Fee: $ _____ per covered employee per month for administration of the package upgrade.

☐ Description: _____
☐ Fee: $ _____ per covered employee per month for administration of the package upgrade.

ADDITIONAL PROVISIONS:

A. Grandfathered Health Plans: Policyholder shall provide HCSC with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the BPA and Group Policy, and Policyholder represents and warrants that such Form is true, complete and accurate. If Policyholder fails to timely provide HCSC with any requested grandfathered health plan information, HCSC may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. Retiree Only Plans and/or Excepted Benefits: If the BPA includes any retiree only plans and/or excepted benefits, then Policyholder represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Policyholder shall indemnify and hold harmless HCSC and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against HCSC in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Policyholder, (d) any provision of inaccurate information, (e) the SBC, (f) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder, and/or (g) Employer's selection of EHB definition for the purpose of the Patient Protection and Affordable Care Act ("ACA"). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. One of those fees is: the Annual Fee on Health Insurers or "Health Insurer Fee."

Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and may use a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee may be used to

help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 and/or other applicable laws may provide for the establishment of a temporary reinsurance program(s) that may be funded by reinsurance contributions or other amounts (collectively, the "Reinsurance Fees or Amounts") collected from health insurance issuers and/or self-funded group health plans. Federal and/or state governments may provide information as to how these Reinsurance Fees or Amounts are calculated. Federal regulations may establish a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees or Amounts may be used to help stabilize premiums in the individual or other markets.

Except for the Cost Plus Program, your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees or Amounts, if any. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees or Amounts, if any.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, HCSC reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require HCSC to pay, submit or forward, on its own behalf or on the Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

Renewals Only: If this BPA is blank, it is intentional, and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Policyholder's first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Any reference in this BPA to eligible dependents may include Domestic Partners or Civil Union partners but will include dependent covered children under the Limiting Age of twenty-six (26), or election made above.

Any reference in this BPA to the Limiting Age for covered children means twenty-six (26) years, or election made above, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the certificate booklet.

Any reference in this BPA to the "Employee plus one dependent" rate structure means "Employee plus one spouse (includes Civil Union partner and/or, if elected, Domestic Partner) or one child."

Any reference in this BPA to the "Employee plus Child(ren)" rate structure means "Employee plus one or more children."

Effective 01/01/2020: Renewing and changing ISL Level to $135,000

All State and Federal Mandates apply

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 weilness credit.

Mike Shank	
Sales Representative	Signature of Authorized Purchaser
822	
District	Title
David Schwimmer	
Producer Representative	Date
Signature of Producer Representative	Witness
VistaNational Insurance Group, Inc	
Producer Firm	
1301 West 22nd Street, Suite 600 Oak Brook, IL 60523	
Producer Address	$_____ Amount Submitted

Producer Number

36-4095485

Producer Tax ID No.

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 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 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

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

Group No(s): H/B10156 PC1286

By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: Village of Oak Park

Address: 123 Madison

City: Oak Park State: IL Zip Code: 60302

Dated this _____ day of _____, _____
Month Year

PBM Fee Schedule Exhibit to the Benefit Program Application

Policyholder: Village of Oak Park **Term:** 01/01/2020 - 12/31/2020	**Insureds:** 388
GUARANTEED TRADITIONAL AGGREGATE PRICING ARRANGEMENT D **(Refer to BPA for Network and Drug List)**	
RETAIL	
Brand	**Generic**
AWP minus	**AWP minus**
HMO 18.50% / PPO 20.65%	HMO 79.00% / PPO 80.50%
DISPENSING FEE	
Brand	**Generic**
$HMO $1.15 / PPO $0.75	$HMO $1.15 / PPO $0.75
MAIL	
Brand	**Generic**
AWP minus	**AWP minus**
20.50%	83.00%
DISPENSING FEE:	$_____
ESN	
Brand	**Generic**
AWP minus	**AWP minus**
HMO 19.75% / PPO 23.00%	80.50% / 82.00%
DISPENSING FEE:	$_____
AGGREGATE SPECIALTY DISCOUNT	
AWP minus	
17.00%	
DISPENSING FEE:	$0.00

Rebate Credits to Policyholder	
Rebate Credit per Insured per month:	$45.89
Administration Fees per Insured per month:	$0.00

Additional Provisions:

Policyholder will be billed for retail brand and retail generic prescriptions, mail brand and mail generic prescriptions, ESN brand and ESN generic, and Specialty Drug Claims (excluding Compound Drug Claims, Foreign Claims, reversed Claims, and out-of-network claims) 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 the Plan's group customers that have purchased the above specific pricing arrangement ("Groups with the Pricing Arrangement") and use the above Network (the "Policyholder's Contract Rates").

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

A. "Brand" products include "Brand Drugs" as defined in this Exhibit; and

B. "Generic" products include "Generic Drugs" as defined in this Exhibit.

Policyholder acknowledges and agrees that Policyholder'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 +/-3% from the applicable AWP discount shown above.

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

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

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

Policyholder will be billed for out-of-network Claims based on the pricing set forth in the Group Administration Document or this 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 Policyholder will be credited, no later than 180 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 Exhibit prior to their anniversary date, for the calendar year ("Per Claim Amount"). Then the Per Claim Amount will be multiplied by Policyholder's total Claims for that calendar year to calculate the reconciliation credit. However, if Policyholder terminates this Exhibit prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Policyholder will not be eligible to receive such credit.
- For purposes of determining if a shortfall exists, Claims billed to Policyholder based on the U&C price will be considered to have $0.00 Dispensing Fees.
- Compound Drug Claims, Foreign Claims, reversed Claims, 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 Policyholder.
- If the AWP discounts and Dispensing Fees shown above are exceeded for Groups with the Pricing Arrangement that use the above Network, then Policyholder 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).

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

Covered Persons' cost share is the applicable Copayment, Deductible, and/or Coinsurance, which Coinsurance is calculated based on Policyholder'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 Policyholder's Claims include 340B pricing.

If changes occur within the pharmacy benefit management marketplace which lead to a significant deviation from the current economic environment, or it is determined that the above pricing was based on an incomplete or erroneous submission of claims data from the Policyholder, both parties agree to engage in good faith negotiations to amend this Exhibit 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 terminate this Exhibit 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 Exhibit, capitalized terms used in this Exhibit shall have the meanings set forth in the Group Administration Document or the applicable Certificate Booklet.

Policyholder payments to the Plan for Covered Services provided by Network Participants are calculated based on the pricing terms set forth in this Exhibit which shall remain in effect for the Term of this Exhibit to the extent described in the Group Administration Document. 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 the Plan and the PBM. As a result, the PBM or the Plan may realize positive margin on prescriptions filled at retail, mail order, ESN or Specialty pharmacies or prescription drug rebates. Policyholder acknowledges that it has negotiated for the specific traditional pricing terms set forth in this Exhibit, and that it and its group health plan have no right to, or legal interest in, any portion of any positive margin retained by the Plan or PBM and consents to the Plan's and PBM's retention of all such amounts.

In the event the Policyholder wishes to implement benefit plan design changes including, but not limited to, implementation of Coinsurance or increase of Copayment/Deductible, the pricing in this Exhibit may no longer be applicable. If such benefit plan design changes impact the existing pricing, new pricing will need to be negotiated. If the parties cannot agree on the terms of any revised pricing, as provided for in this section, either party shall be allowed to terminate this Exhibit with 90 days' prior written notice to the other party. Failure to reach agreement on the new pricing shall not be a breach of contract.

Unexpected generic launches, products launched at risk or under patent litigation are excluded from our Generic guarantees.

Any drug determined to be in short supply based on publications from the Food and Drug Administration ("FDA") or American Society of Health-System Pharmacists ("ASHP") will be excluded from Generic guarantees. In the event these publication sources are not available, the Plan will inform Policyholder of an alternative source. The Plan shall inform Policyholder in writing, in advance if practicable, of any conversion to an alternative pricing benchmark for Covered Services and give Policyholder a reasonable opportunity to review such new benchmark. Thereafter, Policyholder will be deemed to have approved the designation, which will become part of this Exhibit, unless Policyholder terminates this Exhibit in accordance with its terms. Failure to reach agreement on the new benchmark shall not be a breach of contract. The Plan will only use a single nationally recognized pricing source at any given time.

DEFINITIONS

Certain terms are defined in the Group Administration Document, but the following terms and phrases will have the meaning set forth below, for purposes of this Exhibit.

"**Average Wholesale Price**" or "**AWP**" means the average wholesale price of a prescription drug as set forth in the PBM price file at the time a Claim is processed. The price file will be updated no less frequently than weekly through the Pricing Source. The applicable AWP used for retail and mail will be based on the actual NDC-11 of the dispensed product. AWP discounts do not include savings from DUR or other clinical or medical management programs.

"**Benefit Plan**" means the benefit plan document that describes the Covered Prescription Drug Products and Services reimbursement for which an applicable Covered Person of that Benefit Plan is entitled.

"**Brand Drug**" means, except as otherwise designated in the Additional Provisions of this Exhibit, a drug that may be protected by a patent and/or marketed under a trade name which the Pricing Source designates as a Brand Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Brand Drugs as M, N or O in their multi-source code indicator. For the purposes of this Agreement, Brand Drugs are defined as all drugs that have a Medi-Span multisource code field equal to "M", "N", or "O" and also include prescription drug products that are available from no greater than Three (3) manufacturers.

"**Claim**" or "**Claims**" means requests for payment submitted by Network Participants or Covered Persons for Prescription Drug Products and Services.

"**Claims Adjudication**" means the determination of whether a given Claim is entitled to reimbursement pursuant to the terms and conditions of a Benefit Plan and the amount payable to or by a Network Participant or Covered Person pursuant to such Benefit Plan, the applicable Network Contract and any other applicable factors, including any Copayment/Deductible or Coinsurance payable by a Covered Person, as well as drug utilization review. Claims Adjudication shall accommodate any e-prescribing procedures that may be adopted after the date hereof.

"**Compound Drugs**" means a prescription product composed of two or more medications mixed together, with at least one of the component medications being a Federal Legend Drug. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring or sodium chloride solutions are added.

"**Coinsurance**" means that portion of the amount claimed for Covered Prescription Drug Products and Services, calculated as a percentage of the Eligible Charge (or its substitute) for such services, which is to be paid by Covered Persons pursuant to Covered Person's Benefit Plan.

"**Copayment/Deductible**" means a fixed dollar portion of the amount claimed for Covered Prescription Drug Products and Services that is to be paid by Covered Persons pursuant to Covered Person's Benefit Plan.

"**Covered Prescription Drug Products and Services**" means the pharmaceuticals and associated services available to Covered Persons and eligible for reimbursement pursuant to the Covered Person's Benefit Plan, subject to any Copayment/Deductible or Coinsurance. Covered Prescription Drug Products and Services do not include pharmaceuticals and associated services covered under Policyholder's medical benefit.

"**Dispensing Fee**" means the fee required to be paid to the Network Participant for the professional service of filling a prescription and is added to the Ingredient Cost for the prescription.

"**Drug Utilization Review**" or "**DUR**" means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored and acted upon consistent with the Covered Person's Benefit Plan. DUR can be prospective, concurrent or retrospective.

"**Drug List**" means a list of pharmaceutical products which is available to Network Participants, Covered Persons, physicians or other health care providers for purposes of providing information about the coverage and tier status of individual pharmaceutical products.

"**Eligible Claim**" means any Claim or category of Claims that is/are not explicitly identified as excluded from an applicable guarantee component within the Group Administration Document or this Exhibit.

"**Extended Supply Network**" or "**ESN**" means Claims for Covered Prescription Drug Products and Services for which the quantity of medication is at least an Eighty-Four (84) days' quantity supply of medication, provided that the Covered Person's Benefit Plan provides for an ESN benefit.

"**Foreign Claim**" means a Claim for a prescription product or service obtained outside the United States which prescription product or service has an equivalent FDA approved version available for dispensing inside the United States. Prescription products or services that do not have equivalent FDA approved versions are not eligible for reimbursement.

"**Generic Drug**" means, unless otherwise designated in this Exhibit a drug that is not protected by a patent nor marketed under a trade name which the Pricing Source designates as a Generic Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Generic Drugs as Y in their multi-source code indicator. For the purposes of this Agreement, Generic Drugs are defined as all drugs that have a Medi-Span multisource code field equal to "Y", excluding drugs subject to minimum manufacturer requirements set forth in the definition of Brand Drugs.

"**Ingredient Cost**" means the amount required to be paid to a Network Participant for a prescription drug and which, when combined with the applicable Dispensing Fee, constitutes the full amount payable to such Network Participant for the given prescription drug and the professional service of dispensing such drug.

"**Legend Drugs**" means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

"**MAC List**" means the list of unit prices established by PBM for multi-source Covered Drugs, each such unit price specified by Generic Product Identifier ("GPI") and including the dates for which such price was in effect. The MAC List is maintained by PBM and updated from time to time in accordance with this Exhibit.

"**Mail Service**" means the service through which Covered Persons may receive Covered Prescription Drug Products and Services through the mail.

"**Manufacturer**" means a company that manufactures, and/or distributes pharmaceutical drug products.

"**Manufacturer Administration Fee**" means all fixed fees received by PBM from any given Manufacturer relating to administration of Rebates under a Manufacturer Agreement.

"**Maximum Allowable Cost**" or "**MAC**" means the highest Ingredient Cost at which a Benefit Plan will reimburse any Network Participant or Covered Person for a specific drug for products present on the MAC List at the time of service. PBM's MAC Lists applicable to this Exhibit will be available for viewing by authorized representatives of Policyholder after 30 days' prior written request submitted by Policyholder to the Plan, and subject to Policyholder's execution of PBM's non-disclosure agreement(s). Such requests shall be made no more frequently than four (4) times per calendar year. PBM's MAC List will only be made available for viewing at PBM's corporate headquarters or another secured location designated by PBM. PBM's MAC Lists will be the same for all "'Groups with the Pricing Arrangement' and Network" as described in this Exhibit.

"**Network Contract**" has the meaning set forth in the definition of "Network Participant."

"**Network Participant**" means each individual pharmacy, chain or Pharmacy Services Administrative Organizations (PSAO) that has entered into an agreement(s) with PBM or the Plan ("Network Contract") to provide Covered Prescription Drug Products and Services to Covered Persons, as may be amended.

"**Pricing Source**" means Medi-Span, or other such national drug database or alternate pricing benchmark as PBM and the Plan may designate, which establishes and provides updates to PBM no less frequently than weekly or as otherwise required by law, regarding AWP or other alternative pricing benchmark for Covered Prescription Drug Products and Services. The Plan shall inform Policyholder in writing, in advance if practicable, of any conversion to an alternative pricing benchmark for Covered Services and give Policyholder a reasonable opportunity to review such new benchmark. Thereafter, Policyholder will be deemed to have approved the designation, which will become part of this Exhibit, unless Policyholder terminates this Exhibit in accordance with its terms. Failure to reach agreement on the new benchmark shall not be a breach of contract. The Plan will only use a single nationally recognized pricing source at any given time.

"**Provider Tax**" means any tax on a Covered Prescription Drug Product and Service required to be collected or paid by a pharmacy provider for a Covered Prescription Drug Product and Service.

"**Rebate(s)**" means compensation or remuneration of any kind received or recovered by PBM from any Manufacturer which is directly or indirectly attributable to purchase or utilization of Covered Prescription Drug Products and Services by Covered Persons. Rebates do not include Manufacturer Administration Fees which PBM is entitled to retain unless otherwise required by law.

"**Specialty Drugs**" means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected but may also include drugs that are for serious or chronic conditions, have special handling or storage requirements, are infused medications, oral medications and/or that have special handling or storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is determined by PBM or the Plan and subject to change.

"**Usual and Customary**" or "**U&C**" means the price, including any Dispensing Fee, that a Network Participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.

"**Zero Balance Due Claim**" means any Claim where the Covered Person cost share covers 100% of the Eligible Charge for such Claim.