



# Final Renewal 2026-2027

March 19, 2026

# Agenda

1. **Public Comments**
2. **Approve 01/28/2026 Preliminary Renewal Meeting Minutes**
3. **Final Renewal Projections – July 1, 2026**
  - **State of the pharmacy market**
  - **Your Money Line Recap**
4. **Value Added Program Review**
5. **BCBS Legislative Updates**
6. **2026–2027 Budget**
7. **Approval Items**
8. **Executive Committee At-Large Positions – Term 7/1/2026 – 6/30/2028**



# Public Comments



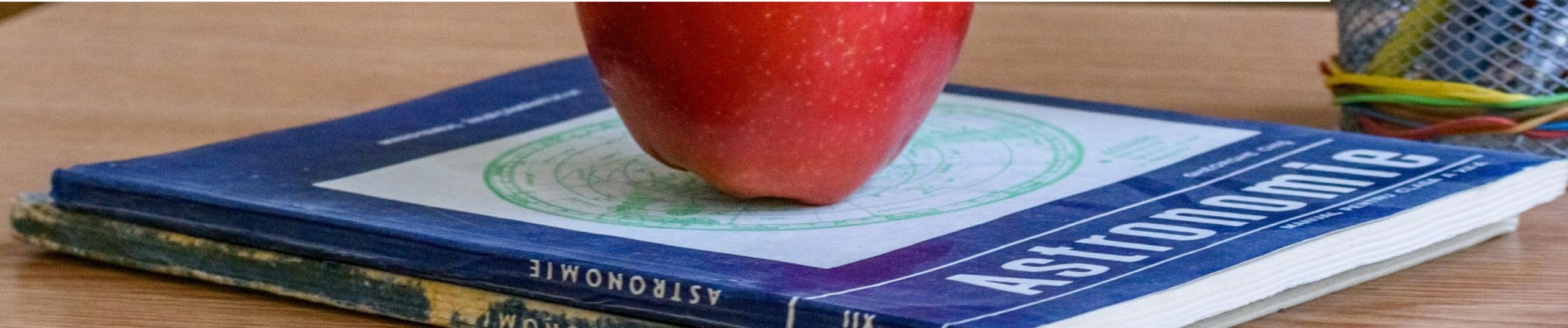
# Public Comments



**The individuals appearing before the Board of Directors are expected to follow these guidelines.**

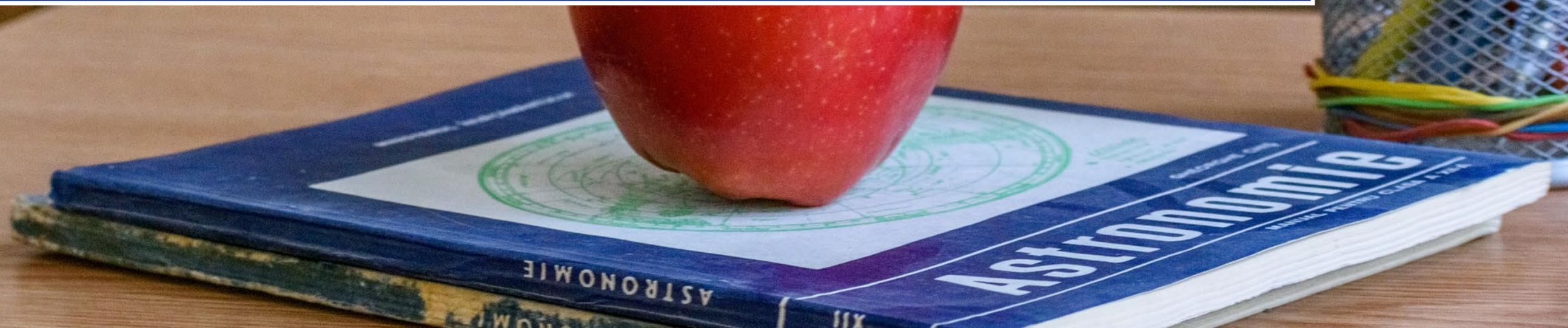
- Address the Board of Directors only at the appropriate time as indicated on the agenda and when recognized by the Chairman of the Board of Directors. A period of up to 30 minutes for public comment will be allowed.
- Identify oneself and be brief. Each speaker will be permitted to speak for no more than 3 minutes.
- Conduct oneself with respect and civility toward others and otherwise abide by EBC Policy.
- If members of the public wishing to address the EBC focus their views on a particular issue, the Chairman or other presiding officer, shall endeavor to allow alternate or multiple views to be addressed.
- Members of the public not able to speak at EBC meetings because the time was taken up by others, may write to the Chairman of the EBC their views, which will be distributed to all EBC members.
- In the event that members of the public should violate the provisions of this policy or otherwise disturb meetings of the EBC, the Chairman or other presiding officer on his or her own discretion or as directed by a motion and vote of the Membership permitted to vote, may require a member of the public to follow these rules and to not otherwise cause a disturbance to the meeting and may take any steps permitted by law to cause such a person to be silenced or removed from the meeting.

**Approve 01/28/2026**  
**Preliminary Renewal Meeting Minutes**

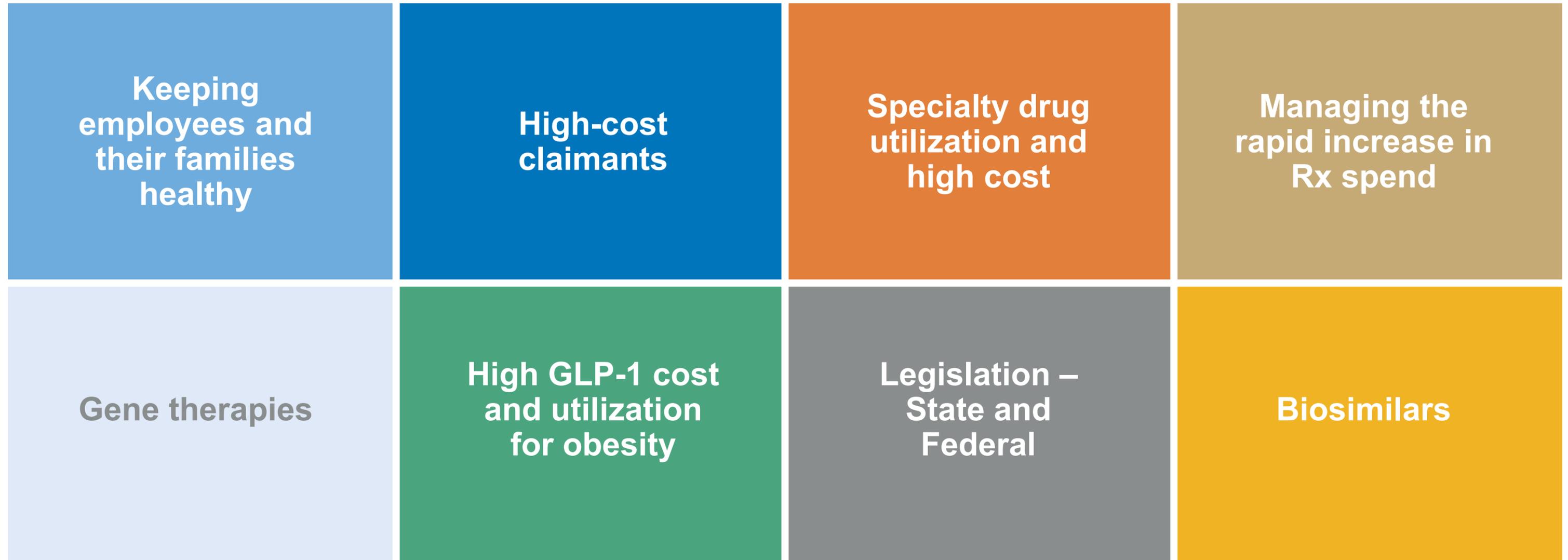


# Final Renewal Projections – July 1, 2026

State of the Pharmacy Market Update



# Key factors driving rapid change in the PBM marketplace



# Legislative Outlook: A Rapidly Changing Industry

- **DOL Proposed Regulations: released 1/30/26, significantly increases reporting requirements for PBMs**
  - Pre-contract disclosure
  - The “actual vs estimated” report
  - Conflict of interest disclosures
  - Audit mandate
- **The CAA, 2026 (HR 7148): signed 2/3/26, mandating transparency for ERISA plans**
  - Minimal direct impact to EBC but signals shift in federal oversight of PBMs
- **FTC Settlement with ESI: announced 2/4/26, resolves the 2024 case regarding anti-competitive practices**
  - Net cost pricing aka point of sale rebates (This is a big deal!)
  - Formulary preferences
  - Reshoring Ascent (GPO/rebate aggregator)
  - DTC integration
  - Transparent pharmacy model
- **TrumpRx.gov: Site went live on 2/5/26**

# GLP-1 Update: Oral solutions have arrived

- **Wegovy pill launched on January 5**
  - ~50K new scripts per week in the first month post launch
  - 15x greater volume than first month of injectable Wegovy
  - Most patients are new – 88% purchased 1.5mg dose
  - 90% of prescriptions were filled through DTC channels (not through a plan benefit)
  - Described as “the best launch ever” by Novo leadership
- **More pills on the way**
  - Lilly planning on launch of oral GLP-1 in Q2 2026
  - Given effectiveness of Zepbound vs. Wegovy, high prescription volume expected once product is available
  - Other manufacturers are currently developing similar solutions, with approval expected in 2027 and beyond



# TrumpRx

## Background & Context

“Few drugs, uneven savings mark early days of Trump’s discount medicines website”

**1** Most-Favored Nation (MFN) Pricing: Manufacturers would commit to price drugs for US consumers no higher than the lowest price they charge comparable countries.

**2** Direct Manufacturer Sales: The government will “facilitate direct-to-consumer” purchasing programs for drugmakers that offer MFN pricing.

**3** Imports of branded drugs may face 100% tariffs unless the manufacturer agrees to onshore production or participate in discount programs.

**4** Manufacturer Engagement: Trump administration has sent letters to major drug companies demanding lower pricing and outlining expectations



Source: IPD Analytics “RxBrief: Potential Impact of Tariffs on Pharmaceutical Industry”  
 Source: IPD Analytics “Legislation and Governmental Insights\_Executive Order on Most-Favored Nation Pricing”  
 Source: STAT “A month in, TrumpRx falls short of president’s grand promises”

Note: Due to the evolving nature of this topic, some information is subject to change. Information is current as of February 2026

# Final Renewal Projections – July 1, 2026

## Executive Summary

PPO Medical	HMO Medical	Dental	Basic Life/AD&D
<b>+16.2%</b> EBC Final Average Adjustment	<b>+16.4%</b> EBC Final Average Adjustment	<b>+3.9%</b> EBC Final Average Adjustment	<b>0.0%</b> Current rates extended through <b>6/30/2027</b>
EBC Average Loss Ratio: <b>109.0%</b>	EBC Average Loss Ratio: <b>105.7%</b>	EBC Average Loss Ratio: <b>98.7%</b>	

# Exhibit A: EBC Experience Period

1/1/2025 – 12/31/2025

<b><u>PPO</u></b>		
A	Revenue	\$431,316,574
B	Claims Under \$1,000,000	\$470,140,880
C	Paid Claim Loss Ratio (B/A)	<b>109.0%</b> Pool Loss Ratio which becomes the center of the Banding Formula (Exhibit C)
<b><u>HMO</u></b>		
A	Revenue	\$ 172,501,186
B	Claims Under \$350,000 plus Physician Services Fees	\$ 182,419,604
C	Paid Claim Loss Ratio (B/A)	<b>105.7%</b> Pool Loss Ratio which becomes the center of the Banding Formula (Exhibit C)
<b><u>DENTAL</u></b>		
A	Revenue	\$ 13,674,772
B	Claims	\$ 13,503,358
C	Paid Claim Loss Ratio (B/A)	<b>98.7%</b> Pool Loss Ratio which becomes the center of the Banding Formula (Exhibit C)

# Exhibit A: Experience Period - PPO

## PPO Experience Period Summary for 2026 to 2027 Renewal

		Experience Period 1/1/25 - 12/31/2025	% of Total Plan Costs
A.	Average Enrollment	21,450	
B.	Revenue	<b>\$431,316,574</b>	
C.	Claims under \$75,000	\$376,612,465	
D.	Claims \$75,000 - \$1,000,000	+	\$93,528,415
E.	Claims under \$1,000,000 (C + D)	=	<b>\$470,140,880</b>
F.	Rx Rebate	+	(\$54,441,829)
G.	Adjusted Claims (E - F)	=	<b>\$415,699,051</b> 94.7%
H.	Plan Expenses		
	1. Claim Administration		\$12,803,145
	2. Reinsurance Premium/Liability	+	\$4,155,736
	3. Consulting Fees	+	\$3,153,407
	4. Healthcare Reform Fees	+	\$150,524
	5. Cooperative Charges	+	\$2,861,671
	6. Total Plan Expenses	=	\$23,124,484 5.3%
I.	Total Plan Costs (G + H5)	=	<b>\$438,823,535</b>
J.	Paid Claim Loss Ratio (E / B)		<b>109.0%</b>
K.	Total Cost Loss Ratio (I / B)		101.7%

# Exhibit A: Experience Period - HMO

## HMO Experience Period Summary for 2026 to 2027 Renewal

		Experience Period 1/1/25 - 12/31/2025	% of Total Plan Costs
A.	Average Enrollment	11,206	
B.	Revenue	<b>\$172,501,186</b>	
C.	Claims under \$75,000	\$116,884,585	
D.	Claims \$75,000 - \$350,000	\$21,468,621	
E.	Claims under \$350,000 (C+D)	\$138,353,206	
F.	Physician Service Fees	+ \$44,066,398	
G.	Total Claims and Physician Service Fees	= <b>\$182,419,604</b>	
H.	Rx Rebate	+ (\$20,073,742)	
I.	Adjusted Claims (G-H)	= <b>\$162,345,862</b>	91.0%
J.	Plan Expenses		
	1. Claim Administration	\$7,553,733	
	2. Reinsurance Premium	+ \$5,354,826	
	3. Consulting Fees	+ \$1,647,400	
	4. Healthcare Reform Fees	+ \$0	
	5. Cooperative Charges	+ \$1,495,225	
	6. Total Plan Expenses	= \$16,051,184	9.0%
K.	Total Plan Costs (I + J5)	= <b>\$178,397,046</b>	
L.	Paid Claim Loss Ratio (G / B)	105.7%	
M.	Total Cost Loss Ratio (K / B)	103.4%	

# Exhibit A: Experience Period - Dental

## Dental Experience Period Summary for 2026 to 2027 Renewal

		Experience Period 1/1/25 - 12/31/2025	% of Total Plan Costs
A.	Average Enrollment	16,467	
B.	Revenue	<b>\$13,674,772</b>	
C.	Claims	<b>\$13,503,358</b>	95.9%
D.	Plan Expenses		
	1. Claim Administration	\$571,076	
	2. Consulting Fees	+	\$0
	3. Total Plan Expenses	=	\$571,076
E.	Total Plan Costs (C + D3)	=	<b>\$14,074,434</b>
F.	Paid Claim Loss Ratio (C / B)		<b>98.7%</b>
G.	Total Cost Loss Ratio (E / B)		102.9%

# Exhibit B: EBC Final Renewal Projection

7/1/2026 – 6/30/2027

<b><u>PPO</u></b>		
A	Projected Revenue	\$449,148,389
B	Projected Total Costs (Claims + Expenses)	\$521,986,848
C	Rate Increase (B/A)	<b>16.2%</b> Pool Average Rate Increase which becomes the center of the Banding Formula (See Exhibit C)
<b><u>HMO</u></b>		
A	Projected Revenue	\$ 177,534,505
B	Projected Total Costs (Claims + Expenses)	\$ 206,648,863
C	Rate Increase (B/A)	<b>16.4%</b> Pool Average Rate Increase which becomes the center of the Banding Formula (See Exhibit C)
<b><u>DENTAL</u></b>		
A	Projected Revenue	\$ 14,639,386
B	Projected Total Costs (Claims + Expenses)	\$ 15,208,198
C	Rate Increase (B/A)	<b>3.9%</b> Pool Average Rate Increase which becomes the center of the Banding Formula (See Exhibit C)

# Exhibit B: Renewal Projection - PPO

## PPO Renewal Projection Summary for 2026 to 2027 Renewal

		Experience Period 7/1/26 - 6/30/2027	% of Total Plan Costs
A.	Projected Monthly Enrollment (#EEs)	21,359	
B.	Projected Annual Revenue	<b>\$449,148,389</b>	
C.	Claims under \$1,000,000	\$543,175,137	
D.	Estimated Annual Rx Rebates	+	(\$60,973,110)
E.	Adjusted Annual Claims under \$1,000,000 (C + D)	=	<b>\$482,202,027</b> 92.4%
F.	Plan Expenses		
	1. Claim Administration		\$13,388,659
	2. Reinsurance Premium/Liability	+	\$4,012,932
	3. Consulting Fees	+	\$3,249,306
	4. Healthcare Reform Fees	+	\$170,120
	5. Cooperative Charges	+	\$4,247,738
	6. Total Plan Expenses	=	\$25,068,754 4.8%
G.	Total Plan Costs (E + F6)		<b>\$507,270,781</b>
H.	Pool Average Rate Adjustment (G / B)		12.9%
I.	Working Cash Fund Build Up		\$14,716,067 2.8%
J.	Revised Total Cost (G + I)		<b>\$521,986,848</b>
K.	Revised Average Rate Adjustment (J / B)		16.2%

# Exhibit B: Renewal Projection - HMO

## HMO Renewal Projection Summary for 2026 to 2027 Renewal

		Experience Period 7/1/26 - 6/30/2027	% of Total Plan Costs
A.	Projected Monthly Enrollment (#EEs)	11,302	
B.	Projected Annual Revenue	<b>\$177,534,505</b>	
C.	Claims under \$350,000	\$154,304,006	
D.	Physician Service Fees	+	\$51,966,982
E.	Total Claims and Physician Service Fees (C + D)	=	\$206,270,988
F.	Estimated Annual Rx Rebates	+	<b>(\$22,364,398)</b>
G.	Adjusted Annual Claims under \$350,000 (E + F)	=	<b>\$183,906,590</b> 89.0%
H.	Plan Expenses		
	1. Claim Administration		\$6,897,837
	2. Reinsurance Premium	+	\$6,135,622
	3. Consulting Fees	+	\$1,719,353
	4. Healthcare Reform Fees	+	\$0
	5. Cooperative Charges	+	\$2,376,914
	6. Total Plan Expenses	=	\$17,129,725 8.3%
I.	Total Plan Costs (G + H6)	=	<b>\$201,036,316</b>
J.	Pool Average Rate Adjustment (I / B)		13.2%
K.	Working Cash Fund Build Up		<b>\$5,612,547</b> 2.7%
L.	Revised Total Cost (I + K)		<b>\$206,648,863</b>
M.	Revised Average Rate Adjustment (L / B)		16.4%

# Exhibit B: Renewal Projection - Dental

## Dental Renewal Projection Summary for 2026 to 2027 Renewal

		Experience Period 7/1/26 - 6/30/2027	% of Total Plan Costs
A.	Projected Monthly Enrollment (#EEs)	16,242	
B.	Projected Annual Revenue	<b>\$14,639,386</b>	
C.	Claims	\$14,644,925	96.3%
D.	Plan Expenses		
	1. Claim Administration	\$563,273	
	2. Consulting Fees	+ \$0	
	3. Total Plan Expenses	= \$563,273	3.7%
E.	Total Plan Costs (C + D3)	= <b>\$15,208,198</b>	
F.	Pool Average Rate Adjustment (E / B)	3.9%	
G.	Working Cash Fund Build Up	\$0	
H.	Revised Total Cost (E + G)	<b>\$15,208,198</b>	
I.	Revised Average Rate Adjustment (H / B)	3.9%	

# Exhibit C: PPO Rate Adjustment

(See Appendix Exhibit 16,17, & 18 for Individual District Rate Adjustments)

PPO Average Loss Ratio = 109.0%		
<u>Paid Claim Loss Ratio</u>	<u>Rate Adjustment</u>	<u># of Members in Band</u>
0.0% to 79.0%	11.2%	0
79.1% to 85.5%	12.2%	2
85.6% to 92.0%	13.2%	6
92.1% to 98.5%	14.2%	14
98.6% to 105.0%	15.2%	26
<b>105.1% to 113.0%</b>	<b>16.2%</b>	<b>43</b>
113.1% to 119.5%	17.2%	10
119.6% to 126.0%	18.2%	13
126.1% to 132.5%	19.2%	5
132.6% to 139.0%	20.2%	5
139.1% +	21.2%	2

# Exhibit C: HMO Rate Adjustment

(See Appendix Exhibit 16,17, & 18 for Individual District Rate Adjustments)

HMO Average Loss Ratio = 105.7%		
<u>Paid Claim Loss Ratio</u>	<u>Rate Adjustment</u>	<u># of Members in Band</u>
0.0% to 75.7%	11.4%	7
75.8% to 82.2%	12.4%	7
82.3% to 88.7%	13.4%	3
88.8% to 95.2%	14.4%	14
95.3% to 101.7%	15.4%	17
<b>101.8% to 109.7%</b>	<b>16.4%</b>	<b>20</b>
109.8% to 116.2%	17.4%	19
116.3% to 122.7%	18.4%	11
122.8% to 129.2%	19.4%	4
129.3% to 135.7%	20.4%	5
135.8% +	21.4%	2

# Exhibit C: Dental Rate Adjustment

(See Appendix Exhibit 16,17, & 18 for Individual District Rate Adjustments)

DENTAL Average Loss Ratio = 98.7%		
<u>Paid Claim Loss Ratio</u>	<u>Rate Adjustment</u>	<u># of Members in Band</u>
0.0% to 68.7%	-1.1%	0
68.8% to 83.7%	1.4%	11
<b>83.8% to 113.7%</b>	<b>3.9%</b>	<b>51</b>
113.8% to 128.7%	6.4%	8
128.8% +	8.9%	0

# Disclaimer - GBS

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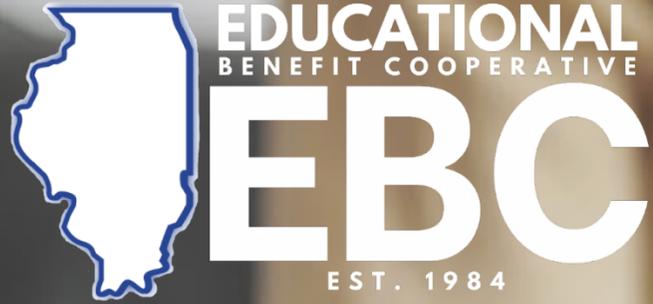
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# Your Money Line

Kelsey Smith, Benefit Consultant

# Your Money Line

## Comprehensive Financial Assistance Program

### Past

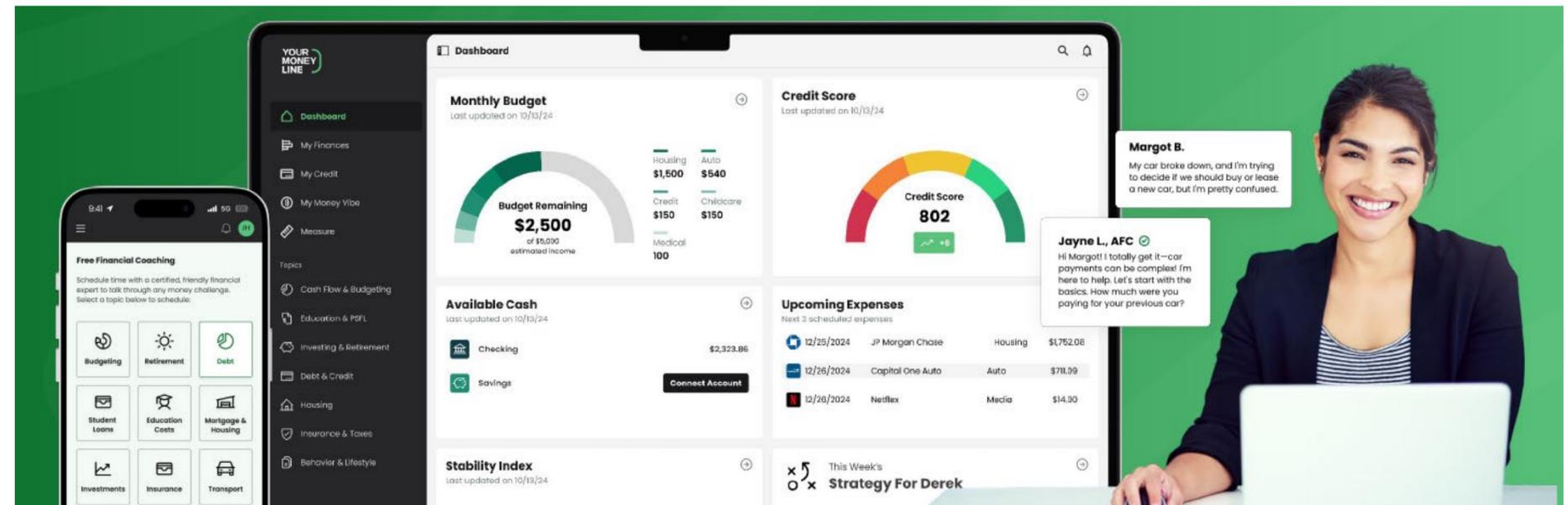
- Credit Card Debit
- Student Loans

### Present

- Medical Expenses
- Public Service Loan Forgiveness

### Future

- Emergency Savings Fund
- Large Purchases (Car/House)
- Retirement Planning



# Your Money Line Features



## Financial Coaching

- Budgeting
- Goal-setting
- Credit building
- Life transitions
- Saving efficiently
- Skill-building & literacy
- Troubleshooting financial emergencies



## Financial Therapy

- Financial Anxiety
- Money Conflict
- Shame/Money Guilt
- Financial Enmeshment
- Compulsive Financial Behaviors
- Self-Sabotage
- Overspending



## Financial Strategy

- Building a long-term road map
- Investment basics
- Risk management strategy
- Cash flow planning
- Introduction to tax planning
- Retirement projections



## Financial Check-ups

- Yearly reviews
- Financial terminology (eg. "What is...")
- Student Loan Status
- Benchmarking (eg. "How much should I save for retirement?")
- General financial questions

## Investment for the Future



- Financial stress is the number 1 source of stress in the U.S today
- **88%** of employees say their financial stress directly impacts their mental health
- When employees lack financial stability, small issues escalate faster into medical claims, pharmacy usage and missed work
- Employers see an estimated **\$18,000** per year in added costs per financially stressed employee, including lost productivity and absenteeism and **\$413** per year increase in healthcare costs

# With YML, you can create meaningful change.

## 97%

of participants feel more confident after meeting with a financial guide.



## \$97,770,420+

in student loans forgiven (and counting)



Employees who use YML contribute **11% more** to retirement after 1 year.



## 14.3%

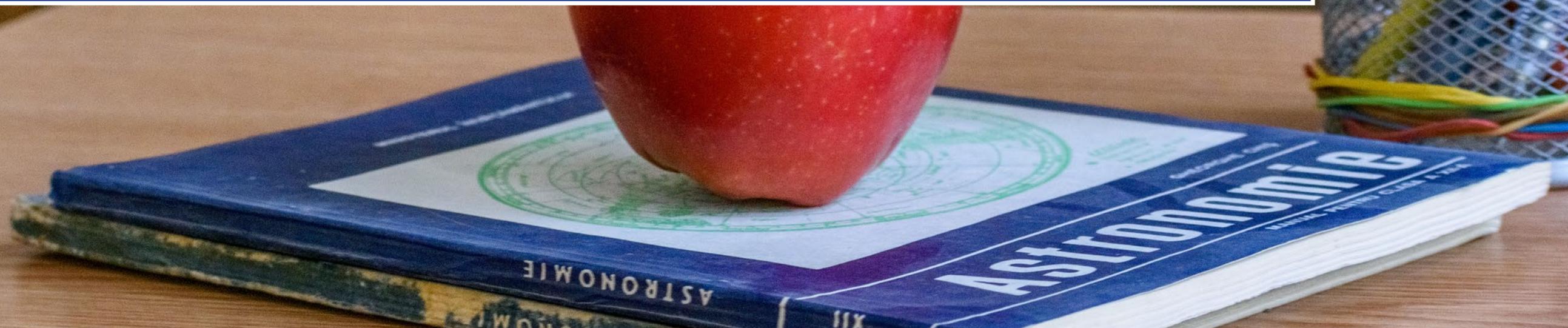
average increase in financial stability users see in 1 year.



YML users are **44% less stressed** about making ends meet every month.



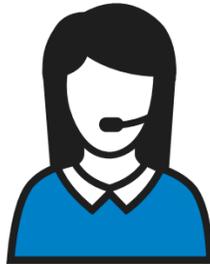
# Value Added Programs Review



# Benefits Value Advisor (BVA) & Member Rewards



## Benefits Value Advisor (BVA)



- Help understand and maximize benefits
- Cost and quality transparency support
- Appointment scheduling
- Referrals to clinical staff / programs
- Prior-authorization coordination
- Clinical decision support tools

**Provides guidance on benefits** such as medical, dental, pharmacy and other available coverages

### **Engagement is key to drive results!**

Increase employee participation and return on investment through engagement with Member Rewards

Members **use their benefits more wisely** and are likely to choose quality, cost-effective care, when needed **and save money!**

## Member Rewards

- Cash rewards motivate employees to shop for options
- Choose a cost-effective provider
- Review quality indicators
- Options with higher savings earn higher rewards
- Higher redirection, more savings for employers

2025 Net Claims Savings

**\$863,000**

2025 Incentives Paid

**1,147**

Average reward paid to member is **\$143**

Top Savings: **MRIs, CT Scans & Colonoscopies**

Top Missed Opportunities: **Sinus Surgery, Cardiology procedure & Cardiac**

# Hinge Health



# Hinge Health's® Digital MSK Clinic™

For Non-HMO Members

## Digital musculoskeletal solution for reducing musculoskeletal pain and spend – effective 7/1/2025

- Based on proven non-surgical care guidelines, Hinge Health provides unlimited annual access to **4 distinct programs**:
  - **Prevention:** At-risk
  - **Acute:** Recent injury
  - **Chronic:** High-risk, now including the Women's Pelvic Health pathway
  - **Surgery:** Pre & Post Rehab, Expert Medical Opinion

**658**

Engaged new members

**1.9%**

Eligible Members Engaged  
(Target 3.75%)

**8.9/10**

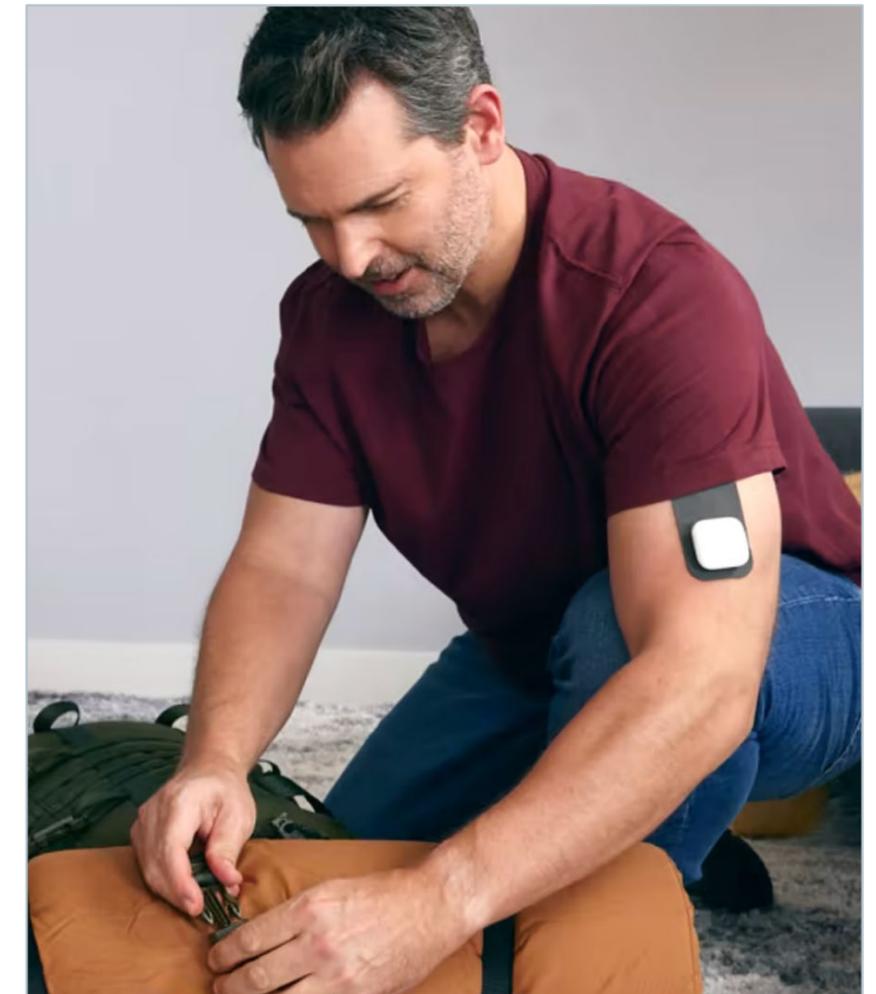
Member Satisfaction

**58%**

Of members chose multiple pain areas

### The 3 most common combinations:

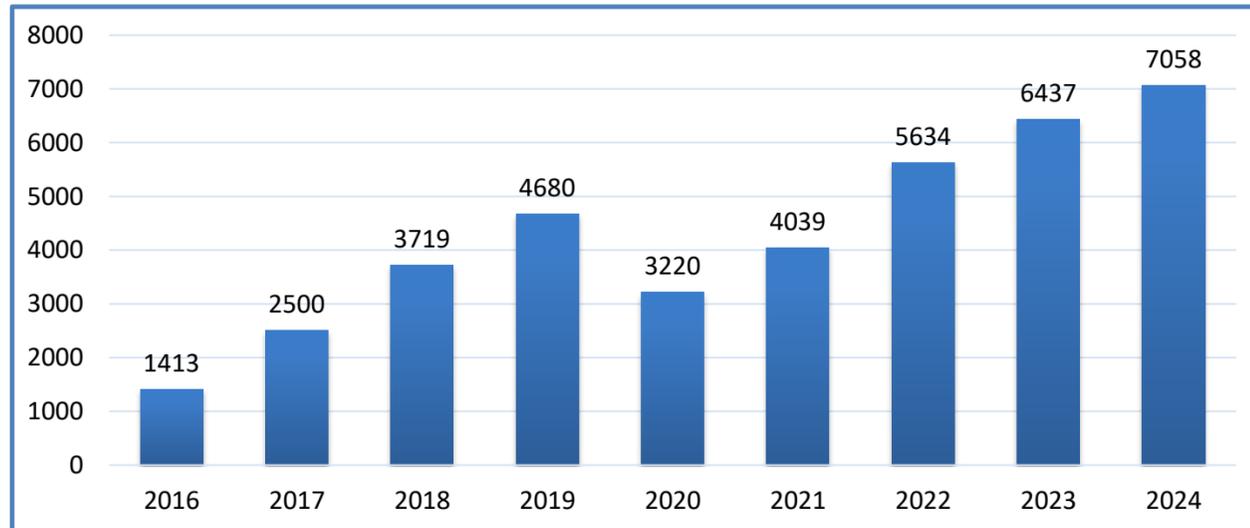
- 1 NECK + BACK + SHOULDER
- 2 BACK + HIP + NECK
- 3 BACK + KNEE + NECK



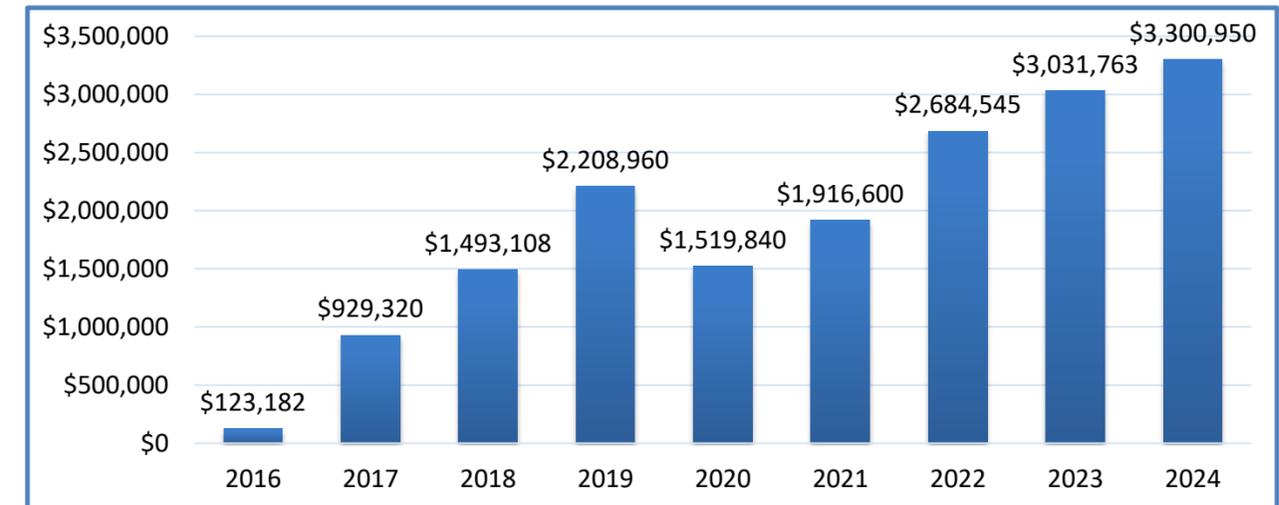
# Teladoc Utilization



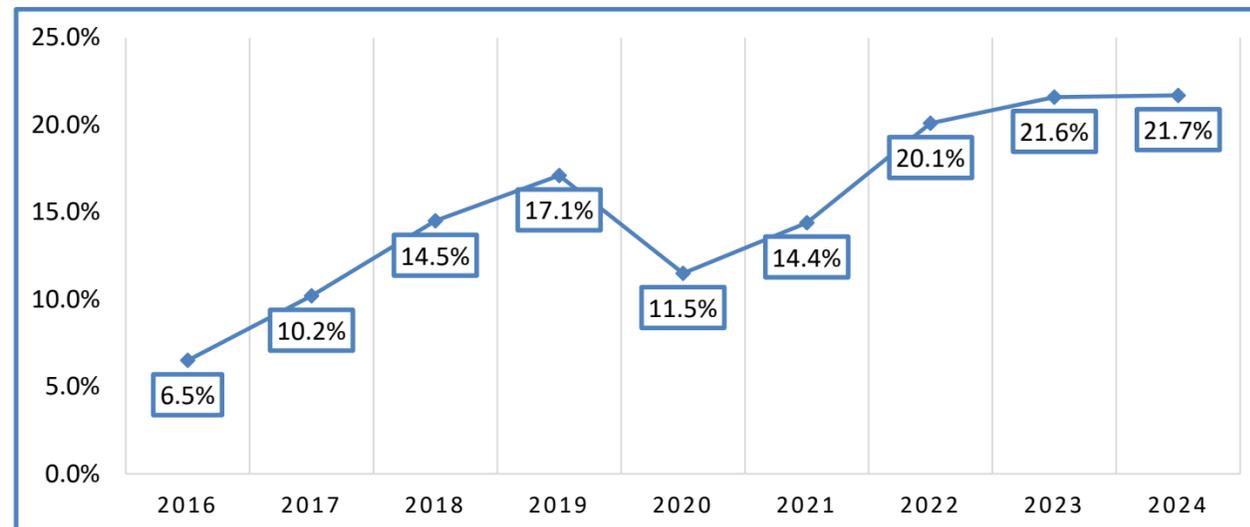
### Number of Visits



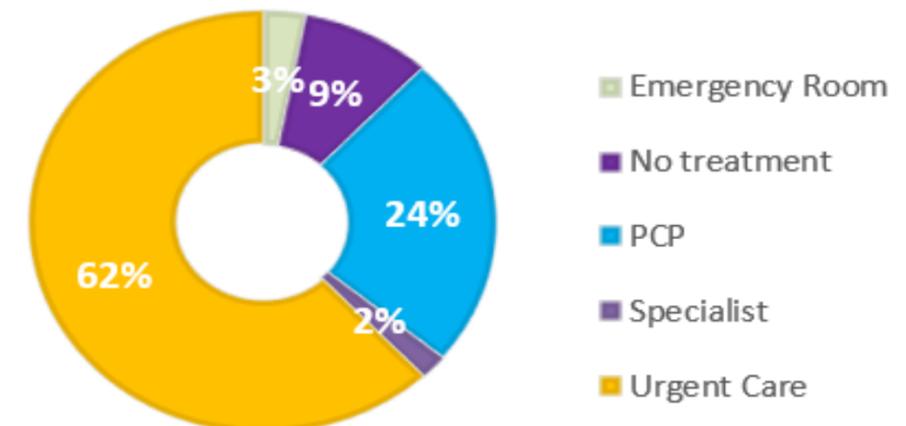
### Net Savings



### Utilization



### Where members would have gone without Teladoc?



# Teladoc Pricing



## 2016

Admin Fee: \$0.85 PEPM

Consultation Fee: \$45

Eligible Employees: 21,816

## 2026 Renewal 3-year Contract

Admin Fee: \$0.83 PEPM

Consultation Fee: \$55

Eligible Employees: 33,159

# BCBS Legislative Updates





BlueCross BlueShield  
of Illinois



# 2026 Legislative Updates

# 2026 Legislative Updates

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# BCBSA Mandate for NSA IDR Administrative Fees and Chargebacks

Effective 1/1/2026 - Applies to all EBC ASO plans

**Summary:** A new Blue Cross Blue Shield Association rule has been issued regarding handling of Independent Dispute Resolution fees effective across all Blue Cross and/or Blue Shield companies. As a result, certain fees associated with the Independent Dispute Resolution process will change.

**What's Changing:** Self-funded group customers will be charged for **all IDR processes initiated on or after Jan. 1, 2026**, regardless of location. With this new requirement from the BCBSA, we are taking this opportunity to simplify, and be more transparent about, the billing for our groups. There will be two separate line items: IDR CMS fee and IDR Arbitration fee.

Going forward:

- Groups will be charged the CMS's IDR admin fee (currently \$115)
- In the event of loss, groups will be charged the IDR entity fee which varies based on complexity & size of review (average \$540) and additional settled claim expense
- We will not charge any negotiation fee for claim disputes resolved in negotiation phase (prior to IDR)

**Background:** A provider dispute and negotiation process was put in place when provisions of the No Surprises Act started for plan years beginning on or after Jan. 1, 2022. This provider-initiated negotiation process – and Independent Dispute Resolution (IDR) process if negotiations fail – is only applicable to NSA-eligible claims. We support our group customers by handling the 30-day provider negotiation process and IDR negotiations for disputes within our five Plan states. Group customers are currently charged administration fees per disputed claim for these services.

# IL Illinois House Bill 3019 (PA 104-0028): HCAPA Expansion/Behavioral Health Travel

Effective 1/1/2026- Applies to all EBC Plans

Illinois Public Act 104-0028 establishes new requirements regarding utilization management and notification of behavioral health treatment.

## **What you need to know:**

The law prohibits prior authorization of the following behavioral health levels of care:

- The first 72 hours for inpatient mental health, inpatient detox, inpatient substance use or residential substance use
- The first 48 hours for partial hospitalization
- The first two business days for other outpatient behavioral health treatment: Transcranial Magnetic Stimulation, Electroconvulsive Therapy and psychological testing

•

## **What's the impact to EBC plans?**

- No review/prior authorization for the first 72 hours for inpatient behavioral health services as listed above.
- No review/prior authorization for the first 48 hours for mental health partial hospitalization.
- No review/prior authorization for the first two business days for other outpatient behavioral health treatment: Transcranial Magnetic Stimulation and psychological testing.

# IL HB 1697: Fee Payment for Prescription Drug Affordability Act (PDAA)

Effective 2025 but billed January 2026 Invoice - Applies to all EBC Plans

One provision of the law requires PBMs to pay the State of Illinois an **annual PDAA fee** of \$15 per covered individual enrolled by the PBM and living in Illinois. The PDAA fee is due annually on Sept. Prime Therapeutics is facilitating the required 2025 PDAA fee payment to the State of Illinois.

Starting with the January 2026 billing statement (sent to groups in February 2026), the pass-through of the PDAA fees for 2025 and 2026 will appear as line-item charges on the monthly billing statement as described below. This will clearly indicate the fee to groups, rather than integrating it into our pricing.

- **The 2025 fee** is based on applicable covered individuals as of Aug. 1, 2025, covering the fee paid to the State of Illinois in 2025.
- **The 2026 fee** will be based on applicable covered individuals as of Dec. 2025, covering the payment that will be paid to the State of Illinois by Sept. 1, 2026.

Monthly payments of each year's \$15 PMPY fee will equate to \$1.25 per month for each applicable covered individual.

The following table is provided as an example to illustrate how this fee will be billed for groups:

Year	Covered Individuals (Members)	Total Fee to State of Illinois	Monthly Billed Pass Through Fee
2025	1,000 as of Aug. 1, 2025	\$15,000 paid in 2025	\$1,250
2026	1,100 as of December 2025	\$16,500 will be paid before Sept. 1, 2026	\$1,375

# Illinois HMO Removing Limits on Rehabilitative/Habilitative Therapy

Effective 1/1/2026 - Applies to all EBC HMO plans

**What you need to know:** We are removing visit limits on rehabilitative and habilitative services when medically necessary for impacted Illinois plans, per Illinois Department of Insurance guidance.

## What's changing?

Currently, Blue Cross and Blue Shield of Illinois plans have a **combined** 60 visit limit on rehabilitative and habilitative services per plan year. This means that a member can have a total of 60 visits between both therapy types.

- The IDOI has clarified that insurers must cover a minimum of 60 visits for rehabilitative services.
- BCBSIL is not able to separate visit limits for rehabilitative and habilitative therapy types. To meet IDOI requirements, we are **removing the visit limits**. Medical necessity, rather than a specific limit, will determine the number of visits.

We will update the paperwork next year with the July 1, 2026, release. While the paperwork will not be updated until July, all impacted plans will have limits removed for rehabilitative therapy effective Jan. 1, 2026.

# IL Illinois House Bill 5395: Step Therapy

Effective 1/1/2026 - Applies to all EBC HMO plans

The Illinois Healthcare Protection Act amends several provisions of the Illinois Insurance Code, including the Managed Care Reform and Patient Rights Act, and specifically step therapy and formulary requirements.

**What you need to know:** The bill requires drug formularies to be posted in a specific, publicly accessible and searchable format, and prohibits formularies from imposing step therapy requirements.

## **What's the impact to Blue Cross and Blue Shield of Illinois plans?**

For groups with Prime Therapeutics® as their pharmacy benefits manager:

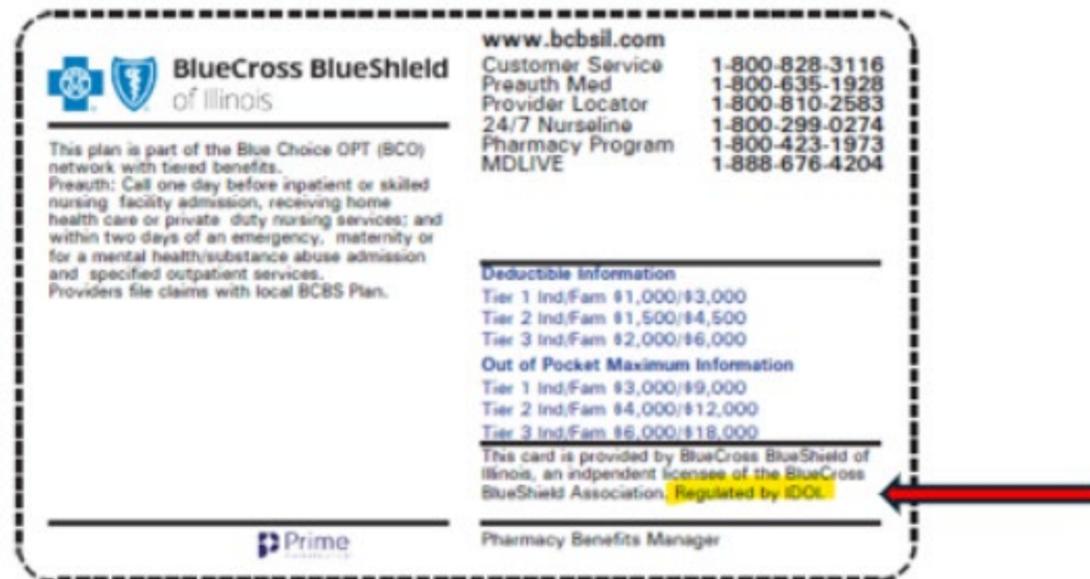
- We have completed our required formulary filings.
- We have posted our Fully Insured drug formularies in the template set by the Illinois Department of Insurance on bcbsil.com.
- Effective **Jan. 1, 2026**, impacted members will not be subject to step therapy.

# Illinois Senate Bill 1346 (PA 104-0375): ID Card Changes Effective 1/1/2026

Illinois Senate Bill (SB) 1346 requires that ID cards indicate whether a plan is fully or self-insured, and if it is subject to IDOI regulation.

For ID cards that BCBSIL produces, the back of Illinois member ID cards will be updated with language indicating whether the plan is subject to IDOI regulation.

EBC Cost Plus HMO ID cards will display Regulated by IDOI.  
EBC Non-ERISA ASO ID cards will display Regulated by IDOI.



# IL Prescription Drug Affordability Act Changes Specialty Definition and Specialty Network

## Effective 1/1/2026 – Applies to all EBC plans

### **Applies to: Illinois Groups with Prime as their PBM**

*"Specialty drug" means a drug that: (1) is prescribed for a person with a complex or chronic medical condition or a rare medical condition; (2) has limited or exclusive distribution; and (3) requires both: (A) specialized product handling by the dispensing pharmacy or administration by the dispensing pharmacy; and (B) specialized clinical care, including frequent dosing adjustments, intensive clinical monitoring, or expanded services for patients, including intensive patient counseling, education, or ongoing clinical support beyond traditional dispensing activities, such as individualized disease and therapy management to support improved health outcomes.*

**What's changing:** BCBSIL will be making terminology changes to member-facing communications and materials to incorporate the PDAA's new specialty drug definition. Members with BCBSIL prescription drug coverage may notice different terminology when viewing their drug list and searching for network pharmacies, such as "specialty and complex care drugs," and "specialty and complex care pharmacies." Based on the above definition, fewer drugs will be classified as "specialty drugs," however there will be no change in how specialty and complex care drugs are covered.

BCBSIL group customers utilizing a pharmacy benefit manager other than Prime Therapeutics® should consult with their PBM for any changes associated with this new definition.

**What's not changing:** Coverage for medications will continue to be based on the member's benefit plan and prescription drug list. BCBSIL members can continue using search tools in their online member account to find covered medicines, estimate costs and find in-network pharmacies.

# IL Illinois House Bill 5142 (PA 103-0720)/5282 (PA 103-0701): Birth Equity/Pregnancy and Postpartum Coverage

Effective upon renewal 7/1/2026 - Applies to all EBC plans

## What you need to know:

- HB 5142 removes cost sharing for abortion care, and requires coverage without cost sharing for certain pregnancy, postpartum and newborn care. It also requires coverage of services provided by doulas and licensed certified professional midwives including home births, maternal home visits, labor support, abortion and miscarriage.
- HB 5282 clarifies that pregnancy and postpartum care must be covered for individuals with mental health or substance use disorder, and anyone who has experienced a miscarriage or stillbirth.
- Members of high-deductible plans with health savings arrangements must meet their deductible first before these services can be covered without cost sharing.

**Abortion coverage:** Surgical abortion procedures will be covered without cost sharing. Abortifacients are already covered without cost sharing per the previous mandate, House Bill 4664 (PA 102-1117).

# IL Illinois House Bill 5142 (PA 103-0720)/5282 (PA 103-0701) Continued

**Pregnancy and postpartum care:** \$0 cost share will apply for covered pregnancy and postpartum services (excluding delivery) performed by a perinatal doula or licensed certified professional midwife within their scope of practice if the providers are in-network.

- BCBSIL is ready to accept requests from doulas and midwives to join our commercial networks. \$0 cost share will apply to covered doula services rendered by BCBSIL in-network doulas. Members may have higher out-of-pocket expenses for services received from doulas who are not participating in a BCBSIL network.
  - Doulas, whether they are in or out of network, should submit claims to BCBSIL for services provided to members. If a doula does not file a claim with BCBSIL, members also have the option to self-submit claims.
  - A referral may be required for services to be covered under HMO Member plans.
- Members are able to receive up to 32 visits per benefit period from an in-network doula without any cost share for covered services rendered.
- \$0 cost share will also apply to covered maternal home visitation services rendered by in-network doulas or in-network social workers for pregnant members and families with children 0-5 years of age.
- For all covered services listed above, HDHP members must meet their deductible first before the services are covered without cost sharing.

# IL Illinois Senate Bill 773 (PA 103-0751): Infertility & Menopause Coverage

Effective upon renewal 7/1/2026 - Applies to all EBC plans

Illinois Senate Bill 773 (PA 103-0751) amends existing infertility coverage language to clarify the services available to members with an infertility diagnosis, as defined in the mandate. The legislation also establishes a new requirement to cover an annual menopause health visit without cost sharing for members 45 years old and older.

## **What's the impact to Blue Cross and Blue Shield of Illinois plans?**

BCBSIL plans will add the following services to their existing infertility treatment:

- Surgical sperm extraction procedures
- Low tubal ovum transfer and intracytoplasmic sperm injection
- Procedures necessary to screen or diagnose a fertilized egg, before implantation, for aneuploidy, chromosome structural rearrangements, and monogenic or single gene disorders.

**Plans will also add coverage without cost sharing for one annual menopause health visit.**

**Note:** This visit may be in addition to a routine annual exam. Members may have both exams covered without cost sharing within the same plan year. HDHP members will receive this service without cost sharing, even if their deductible has not been met first.

# IL Illinois Senate Bill 3414 Continuous Glucose Monitors

Effective upon renewal 7/1/2026 - Applies to all EBC plans

A one-month supply of CGMs, including one transmitter, will be covered without cost sharing when obtained from an in-network provider. Prior authorization and medical necessity review will not be required, and the benefit will be covered under both medical and pharmacy.

For HDHP plans, there is a difference in medical and pharmacy coverage. Recent IRS guidance clarified that CGMs can be considered preventive when prescribed to someone with a diabetes diagnosis. For BCBSIL plans, medical benefits can be tied to a diagnosis; pharmacy benefits cannot.

- **Medical HDHP impact:** One-month supply of CGMs including one transmitter will be covered under the medical benefit without cost sharing before the deductible is met when obtained from an in-network provider, only for a diabetes diagnosis.
  - CGMs purchased over the counter for reasons other than diabetes management are not considered preventive and will be subject to the deductible.
- **Pharmacy HDHP impact:**
  - For standard HDHP plans, CGMs will not be covered without cost sharing before the deductible is met.
  - For custom HDHP plans that have elected to cover CGMs under the preventive drug list, they will be covered without cost sharing before the deductible is met.

Related supplies and education will be covered at the member's standard benefit level.

# IL Illinois House Bill 1141: Anesthesia Time

Effective upon renewal 7/1/2026 - Applies to all EBC plans

Illinois House Bill 1141 requires coverage of medically necessary anesthesia, regardless of the duration, for any service covered by the plan. The bill also prohibits insurers from denying payment for anesthesia solely because it exceeded a preset time limit.

## What's the impact to Blue Cross and Blue Shield of Illinois plans?

BCBSIL currently pays anesthesia claims for medical services based on the time billed and does not deny claims solely because the anesthesia exceeds a specific time limit.

- This mandate **does not change** the way we cover anesthesia for medical services.
- The mandate does not specifically apply to dental plans. Dental claims with anesthesia that extends longer than one hour will continue to be reviewed. Additional documentation may be requested to support the extended time.

# Illinois House Bill 5258 Dependent Parent and Stepparent Coverage

Effective upon renewal 7/1/2026 - Applies to all EBC HMO plans

House Bill 5258 requires health plans that cover dependents to offer coverage to a parent or stepparent who meets the following criteria:

- The parent/stepparent must meet the definition of qualifying relative under [26 U.S.C. §152\(d\)](#)<sup>1</sup> of the Internal Revenue Code (IRC); and
- The parent/stepparent must live within the service area of the subscriber's health plan.

## What's the impact to our plans?

We are updating our coverage to allow subscribers to add dependent parent(s)/stepparent(s) to their plan under the dependent type, "Sponsored Dependent Parent."

- The parent(s)/stepparent(s) of the subscriber can be added if they meet the criteria for qualifying relative and live in the service area of the plan.
- Parent(s)/stepparent(s) of the subscriber's spouse are not eligible for coverage.

References to Dependent Parent will not be on the BPA.

The code for dependent parent/stepparent is "Sponsored Dependent Parent." The relationship code for Sponsored Dependent Parent that should be passed on the 834/5010 file is relationship value 03.(Reminder: This is not the same code as Disabled Adult Dependent ("DIS"))

There are no forms required to certify dependent parent status. BCBSIL will not monitor dependent parent/stepparent eligibility.

# IL Action Required: Illinois House Bill 2385: Colonoscopy Coverage

Effective upon renewal 7/1/2026 - Applies to all EBC HMO plans

Illinois House Bill 2385 requires coverage without cost sharing for colonoscopies when medically necessary.

# IL Illinois Senate Bill 2573: Cancer Coverage for Wigs

Effective upon renewal 7/1/2026 - Applies to all EBC HMO plans

Illinois Senate Bill 2573 requires coverage of one wig or other scalp protheses every 12 months for hair loss due to alopecia, chemotherapy or radiation for cancer or other conditions.

Impacted members will have coverage for one wig per benefit period, subject to the allowed amount of the plan.

# IL Illinois Senate Bill 3599: Mobile Integrated Health

Effective upon renewal 7/1/2026 - Applies to all EBC plans

**What you need to know:** The bill sets criteria for mobile integrated services and requires coverage of those services for members who have either:

- visited the emergency room three or more times in four subsequent months within the past year, or
- been recommended by a health care provider for mobile integrated health services to prevent further hospitalization or inpatient stays.

The law defines **mobile integrated health care services** as health services provided on-site by emergency medical services personnel, including:

- Health assessment
- Chronic disease monitoring and education
- Medication compliance
- Vaccinations
- Lab specimen collection
- Hospital discharge follow-up care
- Minor medical procedures

Mobile integrated health care providers are considered unsolicited providers. Claims for covered health services submitted by emergency medical services providers will be covered at the same benefit level as they would if submitted by any other in-network provider.

- PPO plans will pay at the allowable amount, so it's possible that providers may balance bill members.
- HMO members cannot be balance billed.

# HRSA Federal Mandate – Breast Imaging

Effective upon renewal 7/1/26 – applies to all EBC plans.

**Summary:** HRSA benefits will fall under ACA. Benefits include Breast cancer screenings, including mammograms, MRIs, ultrasounds, and pathology evaluations will be covered as preventive without cost sharing in the following scenarios:

- For members of high-deductible health plans, the screenings will be covered without cost sharing if the member has not been diagnosed with cancer. If the member does have a cancer diagnosis, the deductible would apply first.
- For members of non-HDHP plans, the screenings will be covered without cost sharing regardless of cancer diagnosis.

All HMO plans will receive HRSA benefits and state mandate benefits. All ASO plans will receive HRSA benefits only. EBC wishes to opt into the state mandate for ASO plans this will require approval and claims locks to administer state mandated benefits.

## HRSA vs State mandates

State mandated benefits that are **Richer than HRSA.**

IL HB 4180: Molecular Breast Imaging (MBI) coverage at \$0, Inpatient breast imaging services covered at \$0

3D mammograms are currently covered as an ACA Preventive Service.

# VISCOSUPPLEMENTATION MANAGEMENT

Effective upon renewal 7/1/2026 - Applies to all EBC plans

**Summary:** HCSC will exclude viscosupplementation coverage. Viscosupplementation is a treatment for osteoarthritis of the knee that involves injecting a gel-like substance into the affected joint to mimic natural fluids in the body.

ASO groups can continue coverage as an optional benefit with an exception approval.

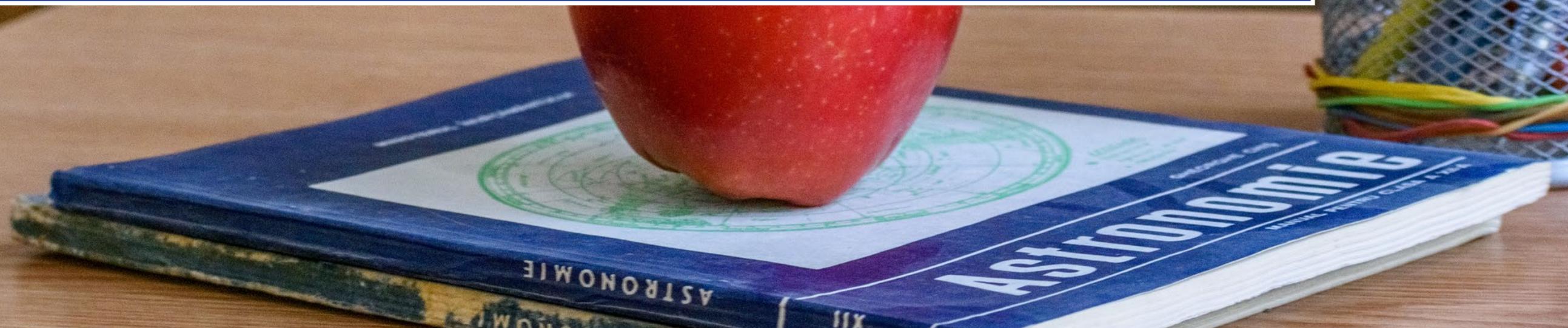
# IL HB 3305 - MAJOR JAW INJURY

Effective upon renewal 7/1/2026 - Applies to all EBC plans

**Summary:** This legislation advises that an insurer must provide coverage for medically necessary care and treatment required to address major injury to the jaw.

Major Jaw Injury – Provides coverage for medically necessary care and treatment required to address major injury to the jaw. Including coverage for procedure codes 21248, 21249, 41822, 41823, 41830, 41874, and D7210. Coverage level will follow surgery benefit level.

# 2026 – 2027 Budget



# EBC Proposed Budget

For the year ending June 30, 2027



<b>EDUCATIONAL BENEFIT COOPERATIVE</b>				
Proposed Budget For the Year Ending June 30, 2027				
	Seven Months Ended January 31, 2026	Projected Twelve Months Ending June 30, 2026	Budget Year Ending June 30, 2026	Proposed Budget Year Ending June 30, 2027
<b>Operating revenues</b>				
<b>Member contributions:</b>				
Health - PPO	\$ 262,354,500	\$ 449,750,571	\$ 458,745,974	\$ 521,986,848
Health - HMO	102,973,992	176,526,843	174,993,009	206,648,863
Dental	8,547,787	14,653,349	15,766,093	15,208,198
Life	1,698,849	2,912,313	3,200,000	3,000,000
<b>Total</b>	<b>375,575,128</b>	<b>643,843,076</b>	<b>652,705,076</b>	<b>746,843,909</b>
Prior year rebates	910,738	3,289,225	-	-
Performance guarantees	324,327	324,327	-	-
Wellness credit	1,000,000	1,000,000	1,000,000	875,000
<b>Total operating revenues</b>	<b>377,810,193</b>	<b>648,456,628</b>	<b>653,705,076</b>	<b>747,718,909</b>
<b>Operating expenses</b>				
PPO Claims Payments	256,651,304	441,098,552	435,887,826	482,677,026
HMO Claims Payments	72,335,998	124,004,568	114,393,745	133,419,218
HMO Physician service fees	27,191,109	46,613,330	46,400,508	51,539,814
Excess Carrier Stop-Loss Premiums	5,100,336	8,743,433	9,097,025	9,673,554
<b>Total Medical Insurance/Claims</b>	<b>361,278,747</b>	<b>620,459,883</b>	<b>605,779,104</b>	<b>677,309,612</b>
Life Insurance Premiums	1,698,849	2,912,313	3,200,000	3,000,000
Dental Claims Payments	8,253,227	14,148,389	15,164,776	14,644,925
<b>Total Insurance/Claims Disbursements</b>	<b>371,230,823</b>	<b>637,520,585</b>	<b>624,143,880</b>	<b>694,954,537</b>
Administration fees	9,919,075	17,004,129	17,022,894	17,157,987
Healthcare reform fees/reporting	165,043	282,931	310,826	313,103
IL PDAA fees	52,326	89,702	-	1,009,785
Member rewards/incentives	255,460	437,931	413,344	903,896
BVA (Benefit Value Advisor)	298,758	512,157	512,304	512,616
Cobra administration	138,239	236,981	236,360	237,200
Consulting/GBS fees	2,809,838	4,816,865	4,839,797	4,968,659
Wellness	1,075,054	1,400,000	1,400,000	1,450,000
Wellness incentive rebate	-	1,700,000	1,700,000	1,792,500
Billing and eligibility administration	749,661	1,285,133	1,317,830	1,322,600
Dependent audit	91,740	157,269	125,000	156,773
Your money line	-	-	-	866,170
Teladoc	409,090	701,297	760,000	752,300
Bank fees	53,726	92,102	95,000	97,000
Accounting fees	154,639	267,120	265,000	290,000
Audit fees	15,000	15,000	15,000	16,500
Legal fees	1,860	3,189	5,000	5,000
Surety/fidelity bond fees	32,584	55,858	55,000	59,000
<b>Total operating expenses</b>	<b>387,452,916</b>	<b>666,578,249</b>	<b>653,217,235</b>	<b>726,865,626</b>
<b>Operating income (loss)</b>	<b>(9,642,723)</b>	<b>(18,121,621)</b>	<b>487,841</b>	<b>20,853,283</b>
<b>Nonoperating revenues (expenses)</b>				
Realized investment income (loss)	2,380,476	4,080,816	4,200,000	4,100,000
Unrealized fair value gain (loss)	814,107	1,395,612	-	-
<b>Total nonoperating revenue (expenses)</b>	<b>3,194,583</b>	<b>5,476,428</b>	<b>4,200,000</b>	<b>4,100,000</b>
<b>Change in net position</b>	<b>(6,448,140)</b>	<b>(12,645,193)</b>	<b>\$ 4,687,841</b>	<b>\$ 24,953,283</b>
Net position, beginning of period	31,802,334	31,802,334		
<b>Net position, end of period</b>	<b>\$ 25,354,194</b>	<b>\$ 19,157,141</b>		

# EBC Historical Analysis

For Years Ending 2018 – 2027 Budget



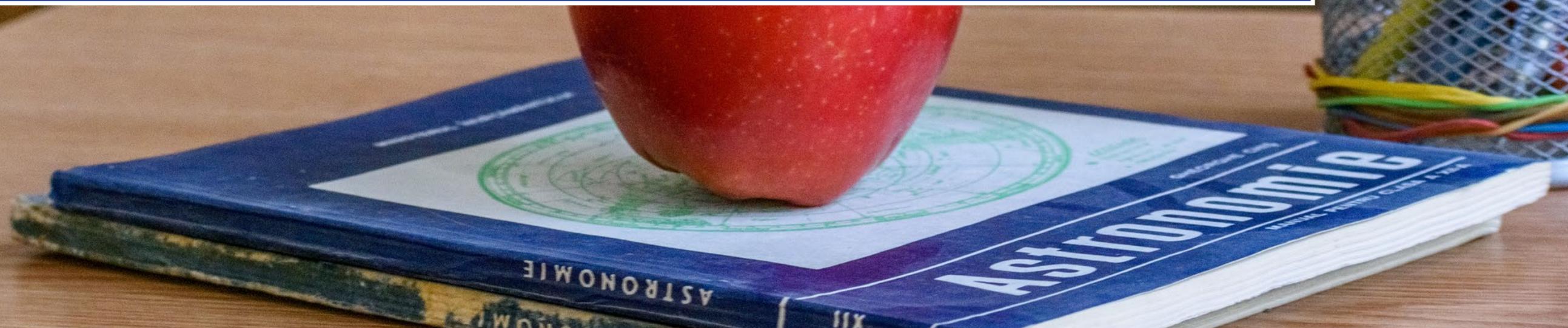
**EBC**  
**Analysis of Revenues, Expenses and Net Position**  
**FYE 2018 - 2027 Budget**

	<u>2018 *</u>	<u>2019 *</u>	<u>2020 *</u>	<u>2021 *</u>	<u>2022 *</u>	<u>2023 *</u>	<u>2024*</u>	<u>2025</u>	<u>Trend 2026**</u>	<u>Budget 2027</u>
Revenues	\$ 368,470,124	\$ 377,129,555	\$ 413,508,882	\$ 441,603,087	\$ 437,305,751	\$ 471,563,005	\$ 556,996,565	\$ 623,731,479	\$ 653,933,056	\$ 751,818,909
Expenses	355,434,255	372,639,598	397,794,792	431,844,501	480,081,428	498,188,191	531,746,082	630,412,097	666,578,249	726,865,626
Actual/Projected net income/(loss)	\$ 13,035,869	\$ 4,489,957	\$ 15,714,090	\$ 9,758,586	\$ (42,775,677)	\$ (26,625,186)	\$ 25,250,483	\$ (6,680,618)	\$ (12,645,193)	N/A
Budgeted net income/(loss)	(1,164,502)	(1,310,511)	(865,635)	(747,441)	(6,768,182)	(2,369,878)	(1,934,822)	2,424,135	4,687,841	24,953,283
Net position	\$ 56,532,584	\$ 61,022,541	\$ 76,736,631	\$ 86,495,217	\$ 43,719,540	\$ 17,094,354	\$ 42,344,837	\$ 31,802,334	\$ 19,157,141	\$ 44,110,424
Net position as % of expenses	15.91%	16.38%	19.29%	20.03%	9.11%	3.43%	7.96%	5.04%	2.87%	6.07%

\* - excludes fair value adjustments

\*\* - trend based upon January 2026 financial statements

# Approval Items



# Annual Approval Motion



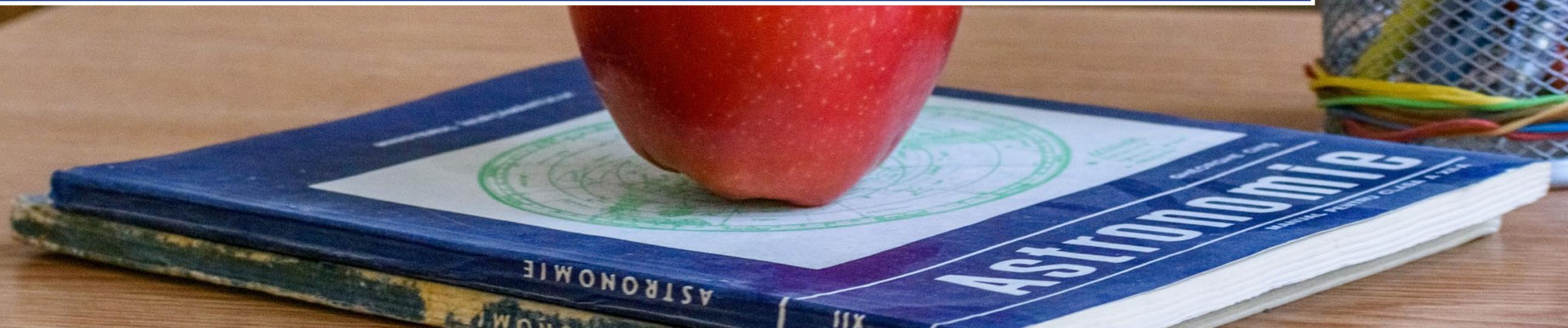
I move that the following items be approved in the 2026-2027 EBC final renewal:

- ✓ Contribution adjustments from the members for the fiscal year beginning July 1, 2026, be set at 16.2% for PPO, 16.4% for HMO, and 3.9% for Dental
- ✓ Businessolver Renewal through 6/30/2031
- ✓ Teladoc Renewal through 6/30/2029
- ✓ Navigate Renewal through 6/30/2029
- ✓ Wellness incentive program through 6/30/2028
- ✓ Your Money Line commencing 7/1/2026 (3 years)
- ✓ Continuation of the Educational Benefit Cooperative through 6/30/2038
- ✓ Proposed budget for 2026-2027

That no funds be allocated this fiscal year from reserve funds (working cash), and that contribution fees be collected from each Member in accordance with this motion.

# Executive Committee At-Large Positions

Term 7/1/2026 – 6/30/2028



# EBC Executive Committee Candidates



## At-Large Members (2026-2028 Term)

### 1. **Jordi Camps (Incumbent)**

East Maine School District 63

Member district for 17 years • Business Manager for 10 years • Current Chair, Trend Committee

### 2. **Mike Loftin (Incumbent)**

Oak Lawn–Hometown School District 123

Member district for 21 years • Business Manager for 23 years • Current Vice Chair, Trend Committee

### 3. **Dr. Abe Singh (Incumbent)**

Grayslake Community High School District 127

Member district for 3 years • Business Manager for 16 years

### 4. **Timothy Gavin**

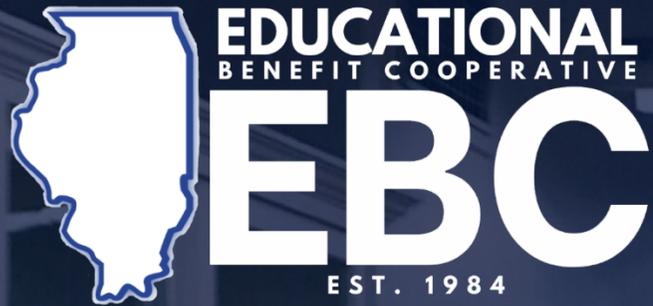
East Prairie School District 73

Member district for 20 years • Business Manager for 8 years

### 5. **Jennifer Hosty**

Berwyn South School District 100

Member district for 21 years • Business Manager for 15 years



# Thank You

## Legal Notice

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This analysis is for illustrative purposes only, and is not a proposal for coverage or a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future healthcare costs including utilization patterns, catastrophic claims, changes in plan design, healthcare trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. See your policy or contact us for specific information or further details in this regard.

While Gallagher does not guarantee the financial viability of any health insurance carrier or market, it is an area we recommend that clients closely scrutinize when selecting a health insurance carrier. There are a of rating agencies that can be referred to including, A.M. Best, Fitch, Moody's, Standard & Poor's, and Weiss Ratings (The Street.com). Generally, number agencies that provide ratings of Health Insurers, including traditional insurance companies and other managed care organizations, reflect their opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile. However, these ratings are not a warranty of an insurer's current or future ability to meet its contractual obligation