Agenda

Jamestown City Council
Monday, February 23, 2026
7:30 P.M.

Council Chambers, Second Floor, Municipal Building
The work session will be held at 7:00 p.m. in the Police Training Room.

STANDING COMMITTEES

Finance, et. al., Committee

1. Resolution authorizing payment of the regular audit.

2. Resolution authorizing the transfer of 17 Dearing Avenue from the City of Jamestown to the Jamestown Urban Renewal Agency for a fee of No Dollars and No Cents ($0.00)

Public Safety

3. Ordinance amending § 300-0317, Accessory structures, of the Jamestown City Code.

4. Ordinance amending § 300-0507, Parking in residential districts, of the Jamestown City Code.

5. Ordinance amending § 300-0206, Fences in residential districts, of the Jamestown City Code.

6. Ordinance amending § 215-33, Heating, of the Jamestown City Code.

7. Ordinance amending § 215-64, Vacation of unfit premises, of the Jamestown City Code.

8. Ordinance amending § 215-44, Garbage and refuse, of the Jamestown City Code.

9. Ordinance amending § 292-1, Storage restricted, [Amended 8-16-2004; 9-26-2005], of the Jamestown City Code.

10. Local Law No. 1 of 2026, a Local law providing for the position of Police Chief.

New Business

11. RESOLVED, That the Mayor be, and hereby is, authorized to enter into an administrative service agreement with Highmark Blue Cross Blue Shield of Western New York, 257 West Genesee Street, Buffalo, New York 14202-2657, to administer the City of Jamestown's self-insured health insurance program for the period of January 1, 2026 to December 31, 2026 at the rate of Forty-Seven Dollars and Fifty-Five Cents ($47.55) per member per month and for the period January 1, 2027 to December 31, 2027 at the rate of Forty-Eight Dollars and Five Cents ($48.05) per member per month and for the period January 1, 2028 to December 31, 2028 at a rate of Forty-Eight Dollars and Fifty-Five Cents per member per month subject to the approval of the Corporation Counsel as to form.

12. RESOLVED, That the Mayor of the City of Jamestown be and she hereby is authorized to enter into an agreement with First Symetra National Life Insurance Company of New York, placed through USI Insurance Services, 7 West Third Street, Jamestown, New York 14701 for a specific excess stop-loss insurance policy for the period January 1, 2026 through December 31, 2026 in the amount of Two Hundred Thousand Dollars ($200,000.00) for specific deductible per participant, an annual unlimited maximum reimbursement, at a cost of Two Hundred Eighteen Dollars and Ninety-Three cents ($218.93) per enrolled employee per month, subject to the approval of the Corporation Counsel as to form.

13. RESOLVED, That the Mayor or her authorized representative be, and hereby is authorized to enter into a health insurance broker agreement with Lawley insurance brokers for the next three years from May 1, 2026 – May 1, 2029 with the following costs per year: 2026- Sixty Thousand Dollars and No Cents ($60,000); 2027- Sixty-One Thousand, Eight Hundred Dollars and No Cents ($61,800); 2028- Sixty-Three Thousand, Six Hundred Fifty-Four Dollars and No Cents ($63,654), subject to the approval of the Corporation Counsel as to form.

14. RESOLVED, That the Mayor or her authorized representative be, and hereby is authorized to enter into a payment in lieu of tax agreement (PILOT) with Southern Tier Environments for Living, Inc. (STEL), 715 Central Avenue, Dunkirk, New York 14048 for a period not to exceed 15 years, for affordable new construction housing located at 31, 53 and 55 Water Street, Jamestown, NY 14701, in an annual amount of Seventy Thousand, One Hundred Sixteen Dollars and Forty-Eight Cents ($70,116.48), subject to the approval of the Corporation Counsel as to form.

COUNCIL MEMBERS: PLEASE CONTACT THE COUNCIL PRESIDENT OR CITY CLERK IF UNABLE TO ATTEND THE REGULAR MEETING AT 7:30 P.M.

February 23, 2026
Resolution #2

BY COUNCIL:

WHEREAS, the City of Jamestown has agreed to transfer the property at 17 Dearing Ave to Jamestown Urban Renewal Agency for No Dollars and No Cents ($0.00).

RESOLVED, that the City Council of Jamestown, New York is hereby authorized to approve the transfer request of 17 Dearing Ave located in Jamestown, New York.

ORDINANCE 2026-01

By Councilmember February 23, 2026

BE IT ORDAINED by the City Council of the City of Jamestown, New York, as follows:

§ 300-0317 Accessory Structures is amended as follows:

A. No accessory structure in an R District shall be located in a front yard or a required side yard.

B. In a C or M District, no processing, storage or accessory structure shall be permitted in any required yard except for gasoline pumps. However, dwellings shall be governed by R District regulations.

C. In any R District, no roofline or projection off of an accessory structure shall encroach more than two feet into any required yard.

D. In any R District, a detached accessory building shall not be located so that any part thereof is closer than 10 feet to any other building.

E. In any R District, no part of an accessory structure shall be nearer than five feet to a side lot line or a rear lot line. [Added 6-14-1999]

F. In any R District, no accessory building shall exceed 720 square feet in area and have a dimension that exceeds 36 feet. [Added 8-27-2012]

G. In any R District, no accessory building shall serve as the principal use building of any property.

H. In any R District, no accessory building shall exceed 18 feet in height, nor shall it be taller in height than the height of the principal use building of the property. [Added 8-27-2012]

ORDINANCE 2026-02

By Councilmember February 23, 2026

BE IT ORDAINED by the City Council of the City of Jamestown, New York, as follows:

§ 300-0507 Parking in residential districts is amended as follows:

A. All automotive use areas shall be surfaced with a durable and dustless material approved by the Building and Zoning Code Enforcement Officer, such as asphalt, concrete, brick, or interlocking paver.

B. For all structures with a residential use, off-street parking areas (not including driveways) for noncommercial vehicles shall be restricted to rear yards.

C. For all structures with a residential use, parking in any front yard shall be restricted to a driveway, provided that no such driveway shall be located in the area which extends from the primary residential structure to the exterior property line. Should the primary residential structure include an attached garage, such driveway shall be restricted to the area which extends from the garage to the exterior property line.

D. All driveways shall be perpendicular to the street of access.

E. Driveways must meet a minimum required width of 11feet and a minimum required length of 18 feet

F. All driveways being newly installed, having a change in size, or material type, excluding resurfacing maintained, must obtain a permit. Fees associated with said building permit shall be as provided in Chapter 175, Licenses and Permits.

ORDINANCE 2026-03

By Councilmember February 23, 2026

BE IT ORDAINED by the City Council of the City of Jamestown, New York, as follows:

§ 300-0206 Fences in Residential Districts is amended as follows:

Definitions

Ornamental Fences: A decorative fence made out of iron, aluminum, steel, or vinyl that provides decorative boundary enclosures. Ornamental or decorative fencing shall not include the use of standard chain link unless vinyl weave has been installed.

A. Except as otherwise regulated under corner visibility provisions and required screening, ornamental fences not to exceed 4 feet in height may be located in a front yard. A fence not over six feet in height may be located in any rear or side yard except an exterior side yard. The installation or maintenance, however, of any wire fence with exposed sharp points, barbs or electric charges in any R District is hereby prohibited.

B. No fence, wall, shrub planting, tree foliage or other permanent structure within five feet of the side of any driveway, which obstructs vision or is three feet or higher above sidewalk level, shall be placed or maintained within eight feet of the point at which said driveway intersects a sidewalk.

C. Installation of all rear and side yard fences, excluding side lots, may be placed directly on the property line, but not over. Any and all post holes shall remain on the property of the fence owner.

ORDINANCE 2026-04

By Councilmember February 23, 2026

BE IT ORDAINED by the City Council of the City of Jamestown, New York, as follows:

§ 215-33 Heating is amended as follows:

§ 215-33 Heating.

A. Equipment. Except in one-family, owner occupied, dwellings, heating equipment shall be maintained so as to provide an indoor temperature of 68º F. measured at a distance of two feet or more from exterior walls and at a level of five feet above the floor.

ORDINANCE 2026-05

By Councilmember February 23, 2026

BE IT ORDAINED by the City Council of the City of Jamestown, New York, as follows:

§ 215-64 Vacation of Unfit Premises is amended as follows:

Part 2. Administration and Enforcement

Article VIII. Administration

§ 215-64. Vacation of unfit premises.

A. Notice of intent to vacate. Whenever the Director of Development determines that a building or part thereof is unfit for human habitation or is an unoccupied hazard or is otherwise in violation of a provision of this chapter, he shall include such finding within a notice of violation, and he shall also include a statement of his intent to order the premises to be vacated or not to be occupied or to be repaired or otherwise brought into compliance and to post necessary notices on the building or part thereof if compliance with the provisions of the notice of violation has not been secured.

B. Notice to vacate. Whenever compliance to a notice of violation has not occurred, the Director of Development may post a notice on the premises and order the premises or any part thereof to be vacated. A copy of any such order or orders shall be served on the owner and/or other responsible person and the occupant in the same manner, as the case may require, as provided for serving notice of violation.

C. Time period to vacate. Any building or part thereof designated as unfit for human habitation and so posted and ordered to be vacated shall be vacated within such time as the Director of Development may specify in the order. No such building or part thereof shall be used for human habitation nor said posted notice removed until written approval is secured from the Department of Development.

D. Removal of posted notice. No person shall deface or remove the posted notice from any building or part thereof which has been designated as unfit for human habitation or an unoccupied hazard, except as provided in Subsection C.

E. Vacated building made secure. The owner, agent, occupant or operator of any building or part thereof which has been designated as unfit for human habitation or an unoccupied hazard shall make such building or part thereof safe and secure for the protection of the public. Any vacated building open at the doors and windows, if unguarded, shall be deemed dangerous to human life and a nuisance within the meaning of this provision. If the owner fails to secure the building, the City may do so and lien the property. The Director shall notify the owner, in the same manner as provided for serving a notice of violation, within 14 calendar days after filing of the lien with the County Clerk.

F. When the Director of Development or his/her agents have designated any structure or any part of it unfit for human habitation and so posted such property and ordered it to be vacated as described in §§ 215-62 or 215-64, it shall be unlawful to reenter the affected structure or any portion thereof for any use of or presence in, or to make repairs thereto pursuant to the issued notice of violation for the property, unless authorized in writing from the Director of Development or his/her agents.

G. Any person violating § 215-64 shall be charged with trespassing and be subject to the penalties under § 215-68.

H. At such time a posted notice is placed on a building, a $250.00 fee shall be issued to the property owner. Failure to remediate violations within six months, and every six months thereafter, the $250.00 fee shall double. If the condemnation occurs due to a fire, the fee shall be deferred for six months. Failure to remediate beyond the initial 6 months will result in a $250.00 fee which shall double every six months thereafter.

ORDINANCE 2026-06

By Councilmember February 23, 2026

BE IT ORDAINED by the City Council of the City of Jamestown, New York, as follows:

§ 215-44 Garbage and Refuse is amended as follows:

DEFINITIONS

Rubbish: Any solid or liquid waste material, including, but not limited to, paper and paper products; rags; trees or leaves, needles and branches therefrom; vines; lawn and garden debris; furniture; cans; crockery; plastic; cartons; chemicals; paint; grease; sludge; oils and other petroleum products; other volatile organic compounds; wood; sawdust; demolition materials; tires; and automobiles and other vehicles and parts for junk, salvage, disposal, or intended ornamental objects.

§ 215-44 Garbage and refuse.

A. The exterior of the property area shall be kept free from organic and inorganic material that might become a health, accident or fire hazard, including but not limited to: [Amended 3-21-2005]

(1) Accumulations of clothing and any other items not designed for outdoor storage;

(2) All household garbage, dead animals, animal and human waste and waste material;

~~(3) Accumulations of dead organic matter and yard debris, with the exception of small accumulations of such material in a maintained compost area on the property and only if such material does not result in a nuisance, such as creating rat harborage or insect infestation; and~~

(3) Accumulations, with or without the intention of use for ornamental lawn décor, of litter, glass, scrap materials including but not limited to wood, metal, paper, tires plastics, junk, combustible materials, stagnant water, or trash.

§ 215-44.1 Compost

A. Composting operations shall be maintained in compliance with the following requirements:

(1) All compost material shall be enclosed in a freestanding compost bin constructed of plastic, metal or other material acceptable to the Commissioner of Building. For residential property larger than one acre in area, yard waste may also be composted in an unenclosed manner. A compost bin shall be no larger in volume than one cubic yard. No more than three (3) compost bins shall be allowed for each property. Compost bins must be rodent proof and five (5) feet or less in height.

(2) All compost materials shall be maintained so as to prevent the harborage of rodents and pests. The presence of rodents or pests in or near the compost bin shall be cause for the Town to issue a violation(s) and order the compost removed.

(3) All compost bins shall be maintained so as to prevent unpleasant odors or any other nuisance condition.

(4) Compost bins shall be located at a minimum of three (3) feet from the rear or side property line and shall be located a minimum of ten (10) feet from any home, patio, pool or similar structure on an adjacent property. Compost bins shall not be located between the front of a principal residential structure and a public or private right-of-way.

(5) No compost bin shall be located where it will impede the natural free flow of storm water drainage.

B. Acceptable Composting Material shall be limited to the following materials:

(1) Yard waste, including leaves, sod, and grass clippings;

(2) Untreated wood, wood chips, and sawdust;

(3) Paper;

(4) Straw;

(5) Vegetables, fruits and their remains, including peels and rinds;

(6) Empty egg shells;

(7) Aquatic weeds;

(8) Coffee grounds and tea leaves;

(9) Evergreen needles;

(10) Hair;

(11) Dryer lint;

(12) Vacuum cleaner dust;

(13) Organic garden waste;

(14) Compost additives that aid the decomposition process,

(15) Bread, rice and pasta.

ORDINANCE 2026-07

By Councilmember February 23, 2026

BE IT ORDAINED by the City Council of the City of Jamestown, New York, as follows:

§ 292-1Storage restricted is amended as follows:

[Amended 8-16-2004; 9-26-2005]

A. It shall be unlawful to park, store or leave any unregistered motor vehicle of any kind upon public property, or for the owner or occupant of any property to allow, permit or suffer the same to be left upon any privately owned property within the City of Jamestown unless the vehicle is stored in a garage of suitable dimensions; or

B. A single motor vehicle, not exceed one (1) per property, licensed or unlicensed, may be stored under a properly fitted car cover in which there is no ripping, tearing, or untethered material exposing any parts of the vehicle, may be parked in the driveway in any R District; or

C. The property owner is a junk dealer duly licensed pursuant to the provisions of Chapter 235, Secondhand Dealers and Junkyards, hereof or the owner of the vehicle is registered by the State of New York to engage in a business requiring limited operation of motor vehicles.

LOCAL LAW NO. 1 OF 2026
A LOCAL LAW PROVIDING FOR THE POSITION OF POLICE CHIEF

BY COUNCIL:

BE IT ENACTED, by the City Council of the City of Jamestown, New York as follows:

Section 1. Section C-32. of the Code of the City of Jamestown is hereby amended to read as follows:

Add: Section C-32A

Subject to the direction of the Mayor and the general rules prescribed by the City Council for the government of the Police Department, the Chief of Police shall have supervision and control over the Police Department of the City and the various members thereof. It shall be his/her duty to ensure that the laws of the state and the local laws and ordinances of the City of Jamestown are enforced in the City by causing the arrest and, in proper cases, the commitment of persons alleged to have violated such laws pending examination before a Magistrate. He/she shall maintain discipline and efficient organization in the police force of the City, and he/she shall have the power to appoint, suspend from office and to remove from the force any police officer or civilian employed in either the Police Department who is incompetent or guilty of neglect of duty or misconduct in office or who for other reason is a bar to the efficiency and discipline of the police force, which removal shall be subject to civil service laws and under the regulations of the local Civil Service Commission.

Section 2. Section C-32. of the Code of the City of Jamestown is hereby amended to read as follows:

Add: Section C-32B

Subject to the direction of the Mayor and the general rules prescribed by the City Council for the government of the Fire Department, the Fire Chief shall have supervision and control over the Fire Departments of the City and the various members thereof. It shall be his/her duty to ensure that the laws of the state and the local laws and ordinances of the City of Jamestown are enforced in the City. He/she shall maintain discipline and efficient organization in the Fire Fighting force of the City, and he/she shall have the power to appoint, suspend from office and to remove from the force any fire officer or civilian employed in the Fire Department who is incompetent or guilty of neglect of duty or misconduct in office or who for other reason is a bar to the efficiency and discipline of the firefighter force, which removal shall be subject to civil service laws and under the regulations of the local Civil Service Commission.

Section 3. Any reference contained in the Code of the City of Jamestown shall be changed to Police Chief.

Section 4. Any inclusion of the fire department under the responsibility of the Director of Public Safety shall be removed.

Section 5. This Local Law shall be effective immediately upon filing with the Secretary of State.

Publication Date

CITY OF
JAMESTOWN
NEW YORK

Agenda Date: _____

Agenda Item: _____

STAFF REPORT

Approved and Forwarded to City Council

Kimberly A. Ecklund, Mayor

DATE: February 17, 2026

TO: Kimberly A. Ecklund, Mayor

FROM: Ericka Thomas, Comptroller

SUBJECT: Renewal of health care plan with Highmark BlueCross BlueShield of Western New York

ACTION: [X] **Resolution** [ ] **Ordinance/Local Law** [ ] **Informational/Report**

ISSUE STATEMENT: City staff is looking to renew the City's health care third party administrator Highmark BlueCross BlueShield.

BACKGROUND: Administration is looking to renew the third-party agreement with BlueCross BlueShield WNY for the City's self-funded health plan, which expires on 12/31/2022. This is a renewal of the same services with Highmark BlueCross Blue Shield of Western New York – the same nationwide provider network will be utilized.

FISCAL IMPACT: Rate of $47.55 per member per month and for the period of January 1, 2026 to December 21, 2026.

$48.05 per member per month and for the period of January 1, 2027 to December 21, 2027 – approximately 1%.

$48.55 per member per month and for the period of January 1, 2028 to December 21, 2028 – approximately 1%

RECOMMENDATION: Approval of contract renewal.

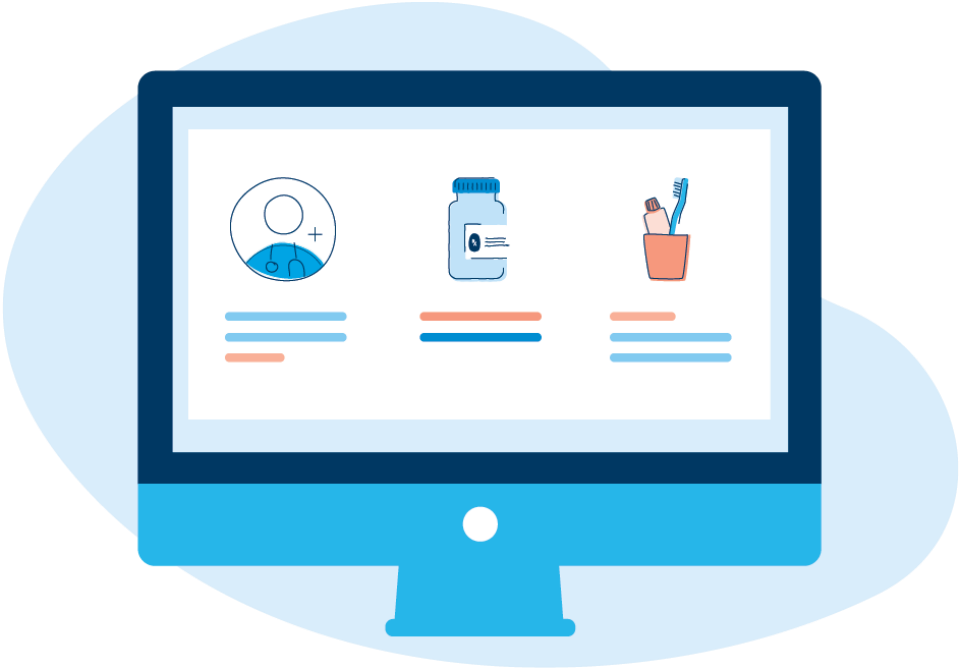
ATTACHMENT(S):

1. Resolution
2. Benefits proposal
3. Rate Sheet

BY COUNCIL:

RESOLVED, That the Mayor be, and hereby is, authorized to enter into an administrative service agreement with Highmark Blue Cross Blue Shield of Western New York, 257 West Genesee Street, Buffalo, New York 14202-2657, to administer the City of Jamestown's self-insured health insurance program for the period of January 1, 2026 to December 31, 2026 at the rate of Forty-Seven Dollars and Fifty-Five Cents ($47.55) per member per month and for the period January 1, 2027 to December 31, 2027 at the rate of Forty-Eight Dollars and Five Cents ($48.05) per member per month and for the period January 1, 2028 to December 31, 2028 at a rate of Forty-Eight Dollars and Fifty-Five Cents per member per month subject to the approval of the Corporation Counsel as to form.

Benefits Proposal



FOR

City of Jamestown

Effective Date: 01/01/2026

Presented by:
Raymond DeTine
Client Manager / NY
(716)378-9860
raymond.detine@highmark.com

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

This response does not constitute an offer to contract. Furthermore, the responses and information provided are based on our current understanding of the requests posed and are limited in scope to the information that was available at the time the responses were prepared.

The recipient of this response acknowledges and agrees that the information contained herein is confidential and proprietary and, as a consequence, may not be disclosed to any third party without the specific written consent of Highmark Blue Cross Blue Shield.

Full disclosure of benefits, provisions and financial arrangements will be contained in the group contract.

More value. More savings. More of everything you need.

Products/Services /Initiatives	Benefit	Your Cost
A Large Network of Health Care Providers	Award-winning, patient-centered care at acute care and community hospitals.	**Included**
Standard Pharmacy Initiatives	Deeply discounted retail and mail order pharmacy networks, competitive rebates and drug management programs to save on prescription costs.	**Included** Additional options available at cost.
Health and Wellness Programs	A comprehensive suite of standard wellness programs engages members and enhances their health.	**Included**
Blues On Call℠ Nurseline	Members get toll-free, 24-hour health-decision support from dedicated clinicians.	**Included**
Open Enrollment Benefit Meetings - Virtual Capabilities	Zoom Technology: allows us to conduct a virtual "live" webinar for the client and members. We can also record / download to Brainshark for future use to share with employees who may have missed the meeting or for any future new hires to explain their benefits. Teams Meeting: Similar to Zoom but for clients who do not want to run the software and utilize Microsoft Office technology from their mainframes. Conference Call: Our team can set up educational conference call meetings with members to review their benefits, available services, value added resources, tools, and of course, answer any questions they may have.	**Included**
Open Enrollment Benefit Meetings - Recorded Capabilities	Brainshark®: We have the capability to prerecord your clients' benefits and messaging in a Brainshark training video. This is a formal presentation that allows members to view a PowerPoint presentation that has been created by Sales.	**Included**
Member Website	Members have a wide range of health assessment and health improvement programs, and provider quality and care cost tools.	**Included**
Employer Website	You have an efficient and effective way to administer your health plan benefits. You can manage enrollment, view current invoices, and general account information. You can also assist employees with benefit questions, ordering ID cards, or finding health care providers.	**Included**
Detailed Care Utilization Standard Reporting Packages	Allows you to monitor care costs, so you can understand your employees' health and wellness needs and enact claim reduction strategies.	**Included** (for groups of 100+) Custom packages available at cost.

Self-Insured Administrative Fee Proposal

HIGHMARK.

City of Jamestown

Summary of Multiple-Year Administrative Services Only Administrative Fees

Summary of Terms:

Average # of Contracts: **403** Average # of Members: **937**

The administrative fees shall be an amount as follows:

Administrative Fees Expressed as $ per Contract Holder per Month			
	01/01/2026	01/01/2027	01/01/2028
Medical Program	$47.55 PCPM	$48.05 PCPM	$48.55 PCPM
Producer Commission	PCPM	PCPM	PCPM

Loyalty Discount[3]	$85,000.00	$40,000.00	$20,000.00

Retail - Guaranteed Discounts	
Network	National Plus
Brand 30	AWP- 19.75%
Brand 90	AWP- 22.75%
Generic 30	AWP- 84.25%
Generic 90	AWP- 84.25%
Dispensing Fees	$0.75 per Claim
Mail - Guaranteed Discounts	
Brand	AWP- 25.00%
Generic	AWP- 87.00%
Dispensing Fees	$0.75 per Claim
Specialty Option 1 - Guaranteed Discounts	
Specialty Pharmacy Program with Free Market Health	AWP- 22.00%
Dispensing Fees	$0.00 per Claim
Specialty Option 2 – Guaranteed Dicsounts	
Accredo Exclusive	AWP- 21.50%
Dispensing Fee	$0.00 per Claim
Open Specialty Network	AWP- 19.00%
Dispensing Fees	$0.75 per Claim
Rebates Option 1	
Comprehensive Formulary	
Arrangement	100% Pass-Through
Retail Brand 30 Script	$423.21
Retail Brand 90 Script	$1,295.48
Mail Brand Script	$1,295.48
Specialty Brand Script	$6,325.56
Accepted	Yes/No
Rebates Option 2	
National Select Formulary	
Arrangement	100% Pass-Through
Retail Brand 30 Script	$465.53
Retail Brand 90 Script	$1,425.03
Mail Brand Script	$1,425.03
Specialty Brand Script	$6,958.12
Accepted	Yes/No

Credit Payment	
Details	City of Jamestown will receive 100% of the rebates for their membership. The rates above represent the minimum floors. If the total annual value of the rebates does not meet these, Highmark will pay the client the shortfall. If the total annual value exceeds these, the client will retain that amount.
Administrative Fee	
Base Admin Fee	Without Truveris: $3.25 Per Script ☐ With Truveris: $4.50 Per Script ☐

Rebates earned will be dependent on Weight Loss Coverage and Policy implemented.

In addition to the above administrative fee, a carve-out fee of $4.00 PCPM applies when you select a stop-loss insurance carrier other than an affiliate of the HM Life Insurance Company[4]. This includes standard reports provided for outside stop-loss carrier.

In addition to the above administrative fee, a carve-out fee of $5.00 PCPM applies when you select a pharmacy benefits administrator (PBM) other than Highmark Blue Cross Blue Shield.

Claim Deposit Fund Requirement – Details will be provided separately. Initial deposit held by the company is due prior to claims being processed and paid. Amount due is calculated using a 14-day average claims volume. Initial amount will be billed separately upon group implementation. Claim Deposit Fund amount is subject to change during term and any revised amount is due in accordance with ASO Agreement terms.

Credit payment - Client will receive 100% of the rebates for their membership. The rates above represent the minimum floors. If the total annual value of the rebates does not meet these, Highmark will pay the client the shortfall. If the total annual value exceeds these, the client will retain that amount.

Any excess achieved for any discount guarantee listed or any excess achieved for any other discount guarantee offered pursuant to this Agreement will be used to make up for, and offset, any deficit in any discount guarantee listed in the table above. Rebate guarantees may not offset any discount guarantees.

Discount Exclusions: (1) home host pharmacy Claims; (2) 340B Claims; (3) Compound Drugs; (4) Member submitted Claims or Paper Claims; (5) Secondary Payer Coordination of Benefits (COB)/Subrogation Claims; (6) Long Term Care (LTC) pharmacy Claims, (7) I/T/U claims, (8) Home Infusion Claims; (9) Military and Veterans Pharmacy Claims; (10) Vaccine Claims; (11) Any Claim that is not a Paid Claim, including rejected, adjusted, and/or cancelled claims or claims processed for returned goods.

Rebate Exclusions: (a) 340B claims; (b) Biosimilars; (c) Compound Drugs; (d) Military Pharmacy Claims; (e) Vaccine Claims; (f) COVID Products; (g) Insulin Claims; (h) Limited Distribution Drugs; (i) Non-Specialty Mail Claims less than 84 days; (j) Over-the-Counter (OTC) Products; (k) and any other Non-Drug (Insulin Syringes, Supply, Devices, etc.) Claims.

When remitting and reconciling minimum Rebate guarantees, Highmark may add “Rebate Credit” value to the total Rebates remitted to Sponsor for each respective Rebate component. “Rebate Credits” shall consist of (i) the differential between the Wholesale Acquisition Cost (WAC) of a lower net cost Brand Drug, including but not limited to a Biosimilar (“Low Cost Brand”), Claim processed and the WAC of the reference Brand Drug, subject to the below cap; and/or (ii) the value of price reductions for rebateable products that have experienced a WAC decrease, measured as the differential between the Baseline WAC of the product and the WAC of the product when the Claim is processed, subject to the below cap. The “Baseline WAC” will be the WAC of the product prior to a reduction in WAC or, as applicable, for Low-Cost Brands, the Baseline WAC will be the WAC of the reference Brand Drug at the time of Claim processing.

Rebate guarantees assume application of Rebate Credit for any products added to the Rebate Credit list. Upon thirty (30) days prior written notice to Sponsor, Highmark reserves the right to modify or amend the financial provisions of the agreement to account for the impact of events identified below. Such notice will include Highmark’s explanation of the manner in which the modification accounts for the impact of the event.

The specialty drug list is subject to change from time-to-time. Highmark Blue Cross Blue Shield reserves the right to add or delete products, or modify rates/pricing terms in the Specialty Pharmacy Program.

[3]Highmark Blue Cross Blue Shield agrees to discount the above medical/prescription fees in an amount equal to the above in recognition of Sponsor’s continued loyalty to Highmark Blue Cross Blue Shield (the Loyalty Discount). Notwithstanding the preceding, if: (i) Sponsor terminates the ASO Agreement before expiration of the period commencing on 01/01/2026 and ending on 12/31/2028 (the ASO Agreement Term); (ii) Highmark Blue Cross Blue Shield terminates the ASO Agreement during the ASO Agreement Term due to Sponsor’s failure to timely remit payment for administrative fees or claims costs, then Highmark Blue Cross Blue Shield shall have the right to reconcile Sponsor’s administrative fee obligations under the ASO Agreement by retroactively revoking the Loyalty Discount to the first day of the ASO

Agreement Term (the True Up). In furtherance of the True Up, Sponsor shall refund the Loyalty Discount to Highmark Blue Cross Blue Shield not later than ten (10) business days following the date of such event. Sponsor expressly acknowledges and agrees that the administrative fees for the ASO Agreement Term (whether or not the Loyalty Discount is offered/accepted or the True Up is triggered) are financially advantageous to both Sponsor and the Plan; and, furthermore, Sponsor acknowledges that it has had an opportunity to consult with legal advisors prior to accepting the preceding terms and conditions regarding the Loyalty Discount and the True Up.

[4]HM Life Insurance Company is a separate company that does not provide Blue Cross and/or Blue Shield products or services. HM Life Insurance Company is solely responsible for issuing stop-loss insurance coverage.

Accepted by:

Employer Rep _____ Title _____ Date _____

City of Jamestown

Highmark Blue Cross Blue Shield Self-Insured Terms and Conditions

Core Services Included in Administrative Fees

Dedicated Account Management Team

- Client Manager, Implementation Service Manager, Client Service Manager, Clinical Strategy Support, Membership Auditor/Supervisor, Supervisor of Operations

Network

- Online directory for most current network, including access to Blue Distinction® Centers for Bariatric Surgery, Cancer Care, Cardiac Care, Cellular Immunotherapy – CAR-T, Fertility Care, Gene Therapy, Knee and Hip Replacement, Maternity Care, Spine Surgery, Substance Use Treatment and Recovery, and Transplants
- Blue Cross Blue Shield Global Core® – global network in over 200 countries

Communications

- Standard ID or custom ID card with logo, color or black (one per member)
- Health Reimbursement Debit Card: Non-customized card included at no additional cost.
- Standard electronic open enrollment / communication materials
- Electronic benefit booklet (also available for members online)
- Electronic Summary of Benefits (SBCs) template
- Open Enrollment Meetings (locations with 100 or more employees)

Administrative Services

- Annual renewal package, admin fee determination and claims projections
- External Audit - 1,000+ contracts are permitted to audit 200 claims and clients with less than 1,000 contracts are permitted to audit 100 claims. (If additional claims are requested, we apply a surcharge of $100/claim for the financial claim audit & $200/claim for the paid claim review.)

Standard File Feeds

- Standard file feeds (using standard file layouts and specified frequencies) for prior carrier accumulator, inbound files from carve-out vendors and outbound files to third party vendors

Web/Digital Services

- Member Self Service Portal and Mobile Web - evaluate health cost and quality-of-care data, find providers, track claims/spending, manage health spending accounts, access wellness and virtual health solutions, view ID card, and leverage a virtual chatbot for questions.
- Employer Self Service Portal – view/manage enrollment, access benefits, view claims, access reports, pay bills
- Mobile Messaging – Secure mobile messaging platform that provides members with information reminders, health solution messages and cost-savings communications to drive engagement in eligible resources

Customer Service/Claims Processing

- Customer Service – Standard Unit
  - Toll-free customer service line, Toll-free group administrator customer service line, Toll free line for open enrollment, Translator assistance, Integrated Voice Response, Chat functionality
- Claims Processing
  - Foreign claim translation and processing
  - Internal appeals according to applicable claims rules

Reporting

- Analytics Navigator Standard Reporting

- 5500 Reporting
  - If applicable, provide data for client to file Schedule C to the Form 5500

Pharmacy Management

- BEST Rx
- CDUR/RDUR
- Channel Alignment (*Specialty Solution*)
- Client and Member Communications
- Client Annual Review Reporting
- Compound Management
- Coordinated Care Management
- Custom System Overrides
- Customized Client Consultation
- Days Supply Limits
- Designated Pharmacy Program for Opioid Management
- Dose Optimization Program
- Drug Pipeline Monitoring
- Drug Quantity Limits
- Electronic Benefit Booklet
- Expedited Appeal
- Flexible Plan Designs
- Foreign Claim Translation and Processing
- Formulary Management
- Fraud, Waste, and Abuse Program
- Mail Order Enrollment Packet
- Maintenance Medication Programs (*Mail or Retail*)
- Managed Prior Authorization Program
- Market Watch Drug Program
- Medical Injectable Drug Program (*Specialty Solution*)
- Member ID Cards
- Member outreach for high cost/high utilization
- Member Pays Difference
- Member Services
- Member Submitted Claims Processing
- My Rx Choices (My Pharmacy Options)
- Optimized Plan Design Modeling
- Peer to Peer Review
- Preventive Drug Utilization Incentive Program
- Preventive Schedule Drug Management
- Product and Services Implementation
- Retail Network Management
- Sempre Health Copay Assistance
- Specialty Pharmacy Network Management (*Specialty Solution*)
- Standard and Custom Reporting
- Standard Appeal
- Standard Prescription Drug Utilization Reporting
- Step Therapy Management
- Telephonic Member Outreach
- Translator Assistance
- Vaccines At Retail
- Worry Free Fills

Required Enhanced Services and Solutions

*Please note clients are automatically enrolled in the following services and solutions. This Pricing is applicable starting 01/01/2026 and ending 12/31/2026. Please note that this pricing is subject to change:

CLAIMS PROCESSING	Fees
External Appeals – Health Care Reform required by PPACA	$1,000/case
Claims Reprocessing Fee	$25/claim
Runout Claims Processing 12 Months of claims runout	100% of ASO fee times last 3 months of enrollment
SHARED SAVINGS AND RECOVERY PROGRAMS	
Coordination of Benefits - Highmark Blue Cross Blue Shield and its recovery vendor may share in percentage of any recovery made pursuant to the coordination provisions of the Plan in compensation for rendering this service to Plan and Sponsor.	35% of recovery
Other Insurance - Highmark Blue Cross Blue Shield and its recovery vendor will undertake reasonable efforts on behalf of the Plan to recover amounts from other accident and injury carriers (e.g., workers' compensation, automobile accident and other accident or injury insurers) to the extent insurance issued by such insurers may be primarily liable for Paid Claims arising from an illness or injury suffered by a Member. Highmark Blue Cross Blue Shield and its recovery vendor may share in a percentage of any recovery from such carriers in compensation for rendering this service to Plan and Sponsor.	35% of savings
Subrogation Management - As used in this booklet, "subrogation" refers to the Plan's right to seek payment and/or reimbursement from a person or organization responsible, or potentially responsible, for the Plan's payment of health care expenses you incurred in connection with an injury.	35% of recovery
Post-Payment Claim Services - Insurance Carrier reviews and investigates potentially fraudulent, waste, abuse or inappropriate billings submitted by providers and members. Whenever amounts recovered from these investigations can be associated with a paid claim under the Plan and result in a paid claim adjustment, Sponsor will	35% of recovery

SHARED SAVINGS AND RECOVERY PROGRAMS	
receive a credit against future paid claims costs in the amount of the recovery, less a percentage fee that may be retained by Insurance Carrier.	
Non-Participating Provider Pricing Services • Negotiation Services • Database Pricing Services • Negotiation Services Cap • Database Pricing Cap	 40% of the difference between billed charges and priced amount 40% of the difference between billed charges and priced amount $50,000 $50,000
Par-Wrap Services	40% of the difference between billed charges and the allowance
Claim Payment Integrity Services	35% of savings
Pre-Payment Services - Such pre-payment activities include but are not limited to: High Dollar Claim Reviews utilizing Itemized Bills, Supplemental Claims Editing, Claim Coding Validation/Accuracy; and Medical Record Reviews.	35% of savings

Additional Services and Solutions

The following is a list of services and fees that may apply. This Pricing is applicable starting 01/01/2026 and ending 12/31/2026. Please note that this pricing is subject to change:

Well360 CHOICE Model - A set of proven solutions, and flexibility to select additional services – ensuring personalized, effective health management.

$0.00 PCPM includes all 4 utilization management programs. $0.50 PCPM applies if all 4 UM programs are not selected.

Please place an X in the far-right columns to indicate all Additional Services you are purchasing.			
CHOICE MODEL		**$0.00 PCPM** [X]	**$0.50 PCPM** [ ]
Utilization Management Programs			
Inpatient Utilization Management	$150/authorization	**Required**	**Required**
Outpatient Utilization Management	$70/authorization	**Required**	
Advanced Radiology and Cardiac Imaging Utilization Management (RadCard)	$20/authorization	**Required**	
MSK Surgery and Interventional Pain Management Utilization Management	$110/authorization	**Required**	
Condition Management and Virtual Care (Paid via claims)			
Mental Well-Being - Virtual solution that includes on-demand digital content, navigation and health coaching services, and expanded access to behavioral health providers.	$0 for self-guided content; $45/Participant/Month (Claims Billed plus variable claims fee		
Well360 Virtual Health - Virtual telemedicine services for urgent care and behavioral health	Variable claims fee	**X**	
Diabetes Management Program - Virtual diabetes care program for type 1 diabetes (13+) and type 2 diabetes (18+)	$75/Participant/Month (Claims Billed)		
Virtual Physical Care Program - Musculoskeletal program for joint health and pelvic floor disorders.	$850 maximum invoiced at 2 milestones (Claims Billed)	**X**	
Noom: Weight Management - Digital weight-loss program focused on behavior change and lifestyle modification; includes GLP-1 content to support members on anti-obesity medications.	$16.50/Participant/Month (Claims Billed) Up to 4 outcome weight loss milestones (5%, 10%, 15%, 20%) - $400 (Claims Billed)		
Noom: Weight Management & Diabetes Lifestyle - Adds a focus on diabetes lifestyle management to the base weight management experience, including GLP-1 content.	$16.50/Participant/Month for Weight + $30/Participant/Month for Diabetes Lifestyle (Claims Billed) Up to 4 outcome weight loss milestones (5%, 10%, 15%, 20%) - $400 (Claims Billed)		
CHF and COPD Management - A virtual care solution	$87/Participant/Month		
Care and Case Management (Activity-Based fees may apply)			
Health Management • 24/7 nurseline	Included	**X**	

• Case, Disease, Behavioral Health and Maternity Management Programs • Health and Wellbeing Programs • Noom: Diabetes Prevention Program (DPP) (Preventive Schedule)	$21/Participant/Month Up to 4 outcome weight loss milestones (5%, 10%, 15%, 20%) - $400 (Claims Billed)	
Integrated Care Team (ICT) - A clinical care team who provides intensive, specialized, and high touch case management services during inpatient admissions.	$400/case	
Medical Specialty Site of Care - Care coordination of Specialty drugs to ensure infusion therapy in the safest, most convenient, cost-effective environment		
Carve Out Care Coordination (opt-out program)	$0.50 PCPM	
Care Coordination Fee (opt-in program)	$200 infusion/eligible claim	
Medical Specialty Site of Care Oncology - Care Coordination of certain Oncology drugs to ensure infusion therapy in the safest, most convenient, cost-effective environment		
Carve Out Care Coordination (opt-out program)	$0.50 PCPM	
Care Coordination Fee (opt-in program)	$1,750 infusion/eligible claim	X
Workforce Support and Other Solutions (Incremental PCPM fee may apply)		
Health and Wellbeing Programs • Blue 365 Wellness Discount Program • My Highmark or AllMyHealth app and web experience	Included	X
Premier Member Service Team (250+ contracts) - A premium designated member service team that provides a personalized experience to engage members in their health care.	$1.50 PCPM includes Health Assessment Only Rewards	
Well360 Virtual Second Opinion (250+ contracts) - The service provides virtual second medical opinions for difficult and complex health conditions and offers diagnostic and treatment plan reviews and consultations virtually with a Cleveland Clinic expert physician.	$1.25 PCPM	
Well360 Virtual Health Enhanced - Virtual telemedicine services for behavioral health, urgent care, primary care, dermatology, and women's health	$0.65 PCPM	
Employee Assistance Program (EAP) & Mental Well-Being Access to coaching and care navigation services, on demand digital programs, work-life resources, and organizational support. EAP Employer Sponsored Session EAP Critical Incident EAP Management Referral	$2.25 PCPM Note: The Mental Well-Being PPPM program fee billed via claims does not apply for EAP clients Activity based variable fees, based individual session type and location, invoiced monthly Activity based variable fees, based on type and duration of support required, invoiced per incident Activity based variable fees, based on type of assessment required, invoiced per case	
Well360 Rewards Packages Preconfigured, flexible, and custom incentive packages that focus on specified activities or outcomes metrics. *50% off discount may be applied for each additional preconfigured Rewards program purchased for the same population; discounts cannot be combined.		
• Health Assessment Only Rewards when purchased in combination with Premier member services	$0.00 PCPM	
• Health Assessment Only Rewards	$0.75 PCPM	
• Preconfigured Rewards when purchased in combination with Premier member services (Cannot be combined with other discounts)	$0.75 PCPM	

• Preconfigured Rewards*	$1.50 PCPM	
• Flexible Rewards	$2.00 PCPM	
• Custom Rewards	$2.50 PCPM	
• Tobacco-Free Reasonable Alternatives	$750	
• Tobacco-Free Attestation and Reasonable Alternatives	$1,300	
• Tobacco-Free Reasonable Alternatives (Digital-Only	$150	
• Tobacco-Free Attestation and Reasonable Alternatives (Digital-Only)	$700	

Noom is offered by your health plan and Noom is an independent company that does not provide Blue Cross and/or Blue Shield products or services. Noom is solely responsible for their services.

Please place an X in the far-left column to indicate all Additional Services you are purchasing.		
PHARMACY MANAGEMENT	**ADDITIONAL SERVICES**	**X**
Free Market Health Specialty	$1.25/Rx script	**X**
RationalMed® – provides timely safety alerts to prevent unnecessary and costly hospitalizations and adverse events	$0.50 PCPM	**X**
RxAdherence® - actionable adherence solution, combines early detection with tailored interventions to improve member adherence. Identifies members at risk of becoming non-adherent in the future and offers them tailored, proactive interventions, before nonadherence becomes a significant issue.	$0.75 PCPM	
Rx Custom Exclusion Drug List	$1,500 one-time set-up	

Please place an X in the far-left column to indicate all Additional Services you are purchasing.		
OPERATIONAL SERVICES		**X**
PHARMACY - Third Party (PBM) Integration		
PBM Integration for a High Deductible Health Plan - Integrating a High Deductible Health Plan (typically a HDHP) with carve-out PBMs. The fee only applies to groups with deductible integration.	$1.50 PCPM in addition to the Rx carve out fee	
Standard: New PBM Integration/Carve-out	$115,000/client made up of $30,000-$50,000 upfront fee with the remaining expense built into pricing to be spread over 18 months or the term of the contract	
Custom: New PBM Integration/Carve-out	$400,000/client made up of $30,000-$50,000 upfront fee with the remaining expense built into pricing to be spread over 18 months or the term of the contract	
Standard: Existing PBM Integration/Carve-out with NO customer requested customizations	$3,000/client upfront fee	
High Touch: Existing PBM Integration/Carve-out	$20,000 set-up/annual maintenance	
Custom: Existing PBM Integration/Carve-out WITH customer requested customizations	$20,000/client set-up (no annual maintenance)	
FILE FEEDS		
Custom: Outbound Third-Party Vendor for Care & Disease Management	$5,000 set-up (per feed)	
Custom: Outbound Third-Party Vendor Enrollment	$3,500 set-up (per feed)	
Custom: Outbound Third-Party Vendor Claims	$3,500 set-up (per feed)	
Custom: Prior Carrier Accumulator	$3,500 set-up (per file)	
Custom: Inbound files from carve-out vendors	$5,000 set-up (per file)	
High Touch Vendor: Price includes all file feed setup requests (bidirectional, eligibility, etc.) regardless of custom or standard and the number of feed setup requests.	$20,000 set-up/annual maintenance	
CUSTOMER SERVICE/CLAIMS PROCESSING		
Claims Fiduciary - Insurance Carrier handles appeals & has final determination.	$1.50 PCPM	**X**
REPORTING		
Non-Standard and Ad hoc Reports - Reports designed according to customer's specified parameters	Quote/report (Cost of development @ $250/hour)	
NETWORK		
GeoBlue℠ - Global specialty health services, technology and insurance provider, Medical Concierge identifies, accesses and pays for quality health care anywhere in the world	Quoted/client	
Away From Home Care (Guest Membership) - Members with an HMO or POS plan with deductibles that do not equal or exceed $1,000		

Please place an X in the far-left column to indicate all Additional Services you are purchasing.		
OPERATIONAL SERVICES		**X**
(single) / $2,000 (family) can obtain coverage through another BlueCross/BlueShield plan when they are "away from home" or outside of the local network service area for an extended length of time. Members are enrolled in a local Blue HMO or POS product and services rendered are treated as in-network when provided by a Blue participating provider. **Note**: In addition to the Set-up Fee, there is a $7.30 per transaction fee. This fee is included in the claim/transaction total.		
• Commercial	$18.50/enrollee Set-up Fee plus per transaction fee	
• Medicare	$19.00/enrollee Set-up Fee plus per transaction fee	
WELLNESS AND PREVENTION		
Preventive Schedule Customization - Annual fee for a Preventive Schedule that differs from Highmark's Standard Preventive Schedule	$10,000	
Well360 Associate Member - When combined with select eligible solutions, offers online and other resources such as Blue365 discounts for employees not covered under the Highmark employer-sponsored medical plan. Select eligible products include wellness (Health and Wellness Rewards, Premier member service, Employee Assistance Program (EAP), My Highmark Enhanced) and non-wellness products (Spending accounts).	$0.00 PCPM	
Wellness Card Program - Administration of a debit card with a predetermined dollar amount that members can use for wellness relates services, such as gym memberships, FitBits and health food store purchases. Administrative fee is allocated per enrollee per month, with claims billed separately on claims invoice.	$1.25/account/month	
Catapult Preventive Screenings - National Preventive Healthcare Practice that provides preventive checkups to the worksite. Licensed nurses perform diagnostic blood work via finger stick, and a board-certified Nurse Practitioner discusses the results privately with the employee via video technology. Employees leave the checkup with their results and actionable items to improve their health including referrals to disease management, wellness, and employer programs. Results are shared with the employee's Primary Care Provider (PCP). If a participant does not have a PCP, Catapult will assist the member with finding a high-quality in-network provider. • Required lead time for any screening request is a minimum of 12 weeks. • Any onsite screening requires a minimum of 30 participants per clinic and preregistration is required. • Additional fees may apply for non-standard clinic hours (outside of 7 am - 7 pm), less participation than estimated, etc. NOTE: Some products and services may be subject to sales tax. Product orders may take up to 10 business days to deliver. Rush shipping fees equal to the greater of $25 or 10% of the product order will be charged if requiring shipping in less than 10 business days. Prices reflect standard model – additional fees may apply for customization.	$195 claims cost applies	
BIOMETRIC SCREENING SERVICES		
Comprehensive Fingerstick (total cholesterol, LDL, HDL, Triglycerides, glucose, and blood pressure)	$48/Participant	
Comprehensive Venipuncture (total cholesterol, LDL, HDL, Triglycerides, glucose, and blood pressure)	$54/Participant	
A la Carte Onsite Add-ons:		
Biometric Screening Counseling (in conjunction with purchased Fingerstick screening option: 5-minute private consultation with qualified health professional regarding screening results).	Add $7/participant	
Measured Height and Weight (calculated BMI)	Add $6/Participant	
Measured Waist Circumference	Add $6/Participant	
Cotinine Venipuncture (Nicotine) with screening	Add $20/Participant	
Cotinine swab test with screening	Add $37/Participant	
A la Carte Offsite options:		
Physician Derived Results (PDR)	$20/Participant	
Screening Lab Vouchers (Full lipid/glucose)	$50/Participant	
Screening Lab Vouchers (Full lipid/glucose/HT/WT/Waist Circumference)	$80/Participant	

Please place an X in the far-left column to indicate all Additional Services you are purchasing.		
OPERATIONAL SERVICES		**X**
3rd Party Biometric Data File		
Clients who contract with their own screening vendor but want results loaded to Health Plan systems for incentive tracking or condition management purposes. Includes providing Health Plan's file requirements, eligibility file with UMI identifiers and testing.	$5,000	
COMMUNICATIONS		
Customized open enrollment / communication materials	Quoted/account	
Printed Benefit Booklets (bulk mailing)	$5.25 booklet	
Printed Benefit Booklets (print and mail to individual members)	$6.75 booklet	
My Highmark Enhanced / AllMyHealth Enhanced Digital Front Door Experience (250+ contracts) - Customized app/web experience with employer-resource education and referrals. A digital front door solution that allows employees to access all their covered benefits and services from one location.	$1.00 PCPM	
Web/Digital Services		
Multi-Factor Authentication (MFA) enabled Single Sign-on (SSO) – MFA enabled SSO is a capability that our clients can use to allow members to link from their employee intranet or similar site more securely into the applicable Highmark website. MFA enabled SSO connections are available for the following web experiences. • MyHighmark.com • AllMyHealth.com		
Initial build fee – With existing acceptable MFA enabled solution	$10,000/MFA enabled SSO connection	
Initial build fee – If no existing acceptable MFA enabled solution	$64,000/MFA enabled SSO connection	
Annual Maintenance fee	$5,000/year	
Customized Member Website Landing Page		
Set-up	Initial build fee – One-time fee based on estimate to build (Flat Dollar Fee)	
Annual Maintenance	Custom Dollar Value/Year Fee (Flat Dollar Fee)	
Ad hoc changes	$200/hour required to make requested changes (Flat Dollar Fee)	
ADDITIONAL PROGRAMS		
Additional Claims to Standard External Audit Service	$100/claim financial claim audit $200/claim paid claim review	
Retiree Drug Subsidy (RDS) Program - The company will work closely with the employer group and Express Scripts to provide eligibility information, assistance with RDS application and reconciliation and annual plan updates.	$1.75 PMPM	
Vision (Discount Program and Stand-Alone Plan) - Includes claims administration, network maintenance, and billing and enrollment functions for a stand-alone vision or vision discount program. We work with you to craft a plan design that provides the right level of services to meet your employees' vision needs.	$6.00/claim	**X**

The proposed administrative fee represents an offer of a multiple-year agreement and are subject to the conditions and reservation of rights noted herein. This offer does not apply to an increase attributable to federal/state taxes, fees, surcharges, assessments or changes to mandated benefits and coverage requirements, regardless of whether such taxes, fees, surcharges, assessments or mandated benefits or coverage requirements were in effect before or after the date of this offer.

Notwithstanding anything in this proposal to the contrary, Sponsor understands and agrees that pharmacy rebates and, thus, Highmark Blue Cross Blue Shield's ability to extend the pharmacy rebate terms, is subject to the following:

- The terms of agreements that Highmark Blue Cross Blue Shield or its pharmacy vendor has with brand drug manufacturers;
- Changes in law; which, among other things, may be revised due to changes in applicable laws, regulations, executive orders, agency actions, court orders and/or legal settlements; or
- Actions taken by a pharmaceutical manufacturer that has an adverse effect on the availability of the rebate (including, but not limited to, legal settlements)

All of the preceding are, hereinafter, referred to as "Rebate Changes".

Sponsor understands and agrees that Highmark Blue Cross Blue Shield may, correspondingly, reduce the preceding Pharmacy Rebate credits in the event of such Rebate Changes. Highmark Blue Cross Blue Shield shall inform Sponsor of an adjustment to Pharmacy Rebate credits in writing not later than thirty (30) days prior to implementing the adjustment.

Highmark Blue Cross Blue Shield further reserves the right to adjust the Pharmacy Rebate credit if any of the following were to occur during the term of this contract:

- There is a material change in the utilization, size, demographics or gender distribution of Sponsor's membership, in each case as compared to that reflected in the base data used to price contracted guarantees, that results in a change in the drug mix which has a positive or negative impact on the Rebates that Highmark would otherwise receive so as to have a positive or negative impact on Highmark's ability to meet the Pharmacy Rebate guarantees; or
- Client-initiated change to pharmacy benefit program or plan design (which may include, but not limited to, copays, network, formulary, specialty drug list, or utilization management edits); or
- Product offering decisions by drug manufacturers that result in a reduction of rebates, including the introduction of a lower cost alternative product which may replace an existing rebateable brand product; an unexpected launch of an interchangeable version of a brand product; or a branded product converted to OTC status, recalled, or withdrawn from the market; or a material reduction in Wholesale Acquisition Cost (WAC); or
- Sponsor materially changes the formulary or benefit design in the Plan; or
- Sponsor elects to use on-site clinics or pharmacies to dispense Covered Drugs to Members; or
- Rebates materially decrease with respect to the Plan because Brand Name Drugs move off patent, authorized generic is launched, or biosimilars are introduced; or
- In the event a public health emergency is declared affecting (i) one or more Highmark service locations that support Services under this SOW; and/or (ii) geographic area(s) of work or residence of ten percent (10%) or more Members. The preceding shall apply whether a public health emergency is declared by the World Health Organization or by an agency or instrumentality of government in the relevant geographic area(s) having such authority.

Sponsor understands and agrees that the Pharmacy Rebate credits are voided as of the date Sponsor implements a program or other initiative (either directly or through a third party) that has the effect of changing the mix of drugs subject to the Pharmacy Rebate.

Highmark Blue Cross Blue Shield reserves the right to modify the monthly administrative fee amounts if any of the following were to occur during the term of the contract.

- Sponsor does not enroll a minimum of 100 eligible contracts;
- Sponsor requests additional effective dates;
- Sponsor's enrollment increases or decreases by more than ten percent (10%) from the level of the base experience period when the fee was determined;
- There is a change in state, federal or other law (including any change in mandated benefits, taxes, fees, surcharges or other assessments) or the interpretation of such laws; or
- There is a requested or mandated revision in the coverage provided under the contract.

It is the Employer's responsibility to ensure health plan meets the minimum value requirement as set forth in PPACA. The Company makes no representation as to whether this health plan meets the minimum value requirement. Refer to the Benefit Matrix for product and plan specific information. Information regarding applicable commissions will be made available upon request.

In response to the Patient Protection and Affordable Care Act (PPACA) legislation, there is a tax that may impact the cost of providing coverage to your employees. This tax is as follows:

- Patient-Centered Outcomes Research Institute (PCORI) Fees - Sponsors of self-insured plans are required to pay the tax on their own behalf. This tax continues to be in effect until plan years ending September 30, 2029. The amount due per life is subject to annual adjustment.

Highmark Blue Cross Blue Shield's administrative fee does not include costs associated with federal and state taxes, surcharges and fees, including those imposed by the Patient Protection and Affordable Care Act of 2010 (e.g., Patient-Centered Outcomes Research Institute). The Sponsor will agree to reimburse Highmark Blue Cross Blue Shield for taxes, surcharges or fees assessed against Highmark Blue Cross Blue Shield or that Highmark Blue Cross Blue Shield is required to pay by law or regulation (whether in effect now or in the future) relating to the Sponsor's health plan, including, among other things, benefits paid and membership (exclusive of taxes assessed on the basis of Highmark Blue Cross Blue Shield's net income). Highmark Blue Cross Blue Shield has the authority and discretion to determine whether any such tax should be paid or disputed. Highmark Blue Cross Blue Shield will act reasonably when making that determination.

Sponsor acknowledges and agrees that it has had the opportunity to discuss Sponsor's specific plan design requirements with Highmark Blue Cross Blue Shield prior to signing this proposal; and, further, understands, acknowledges and agrees that Highmark Blue Cross Blue Shield may require that Sponsor execute an indemnification agreement as a condition to Highmark Blue Cross Blue Shield's administration of certain non-standard benefit/coverage exclusions (Exclusions) in light of the potential risk associated with each. In this regard, Sponsor acknowledges that it has had an opportunity to review a listing of Exclusions standardly administered by Highmark Blue Cross Blue Shield and for which no indemnification will be required as of the date of this Proposal.

Please contact the Highmark Blue Cross Blue Shield Representative named on the front of this proposal for additional information.

I have read and understand the financial language included in this proposal and acknowledge that I had the opportunity to have each term and condition explained to me in full. Please note that benefit changes after distribution of a Summary of Benefits and Coverage (SBC) may require modification and redistribution of the SBC and/or advance notification to participants and beneficiaries prior to the effective date of the benefit change.

Accepted by _____ Title _____ Date _____

NETWORK ACCESS FEES

BLUECARD® ACCESS FEE DISCLOSURE STATEMENT

Highmark Blue Cross Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever members access health care services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Programs and presented to us for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this agreement are described generally below:

Typically, members, when accessing care outside the geographic area we serve, obtain care from health care providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in the other geographic area (“Host Blue”). In some instances, members may obtain care from non-participating health care providers. The payment practices in both instances are described below.

BLUE CARD PROGRAM:

Under the BlueCard Program, when members access covered health care services within the geographic area serviced by a Host blue, we will remain responsible to the client for fulfilling our contractual obligations. However, in accordance with applicable Inter-Plan Programs polices then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers. The financial terms of the Blue Card Program are described generally below. Individual circumstances may arise that are not directly covered by this description. However, in those instances, our action will be consistent with the spirit of this description.

LIABILITY CALCULATION METHOD PER CLAIM

The calculation of member liability on claims for covered health care services processed through the BlueCard Program will be based on the lower of the participating health care provider’s billed covered charges or the negotiated price made available to us by the Host Blue.

The calculation of your liability on claims for covered health care services incurred outside the geographic area we serve and processed through BlueCard will be based on the negotiated price we pay the Host Blue.

The calculation of the client’s liability on claims for covered health care services processed through the BlueCard Program is based on the negotiated price made available to us by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s health care provider contracts. The negotiated price made available to us by the Host Blue may represent a payment negotiated by a Host Blue with a heath care provider that is one of the following:

- **An actual price.** An actual price is a negotiated payment without any other increases or decreases, or

- **An estimated price.** An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or
- **An average price.** An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues, using either the Estimated Price or Average Price may, in accordance with Inter-Plan Programs Policies, prospectively increase or reduce such prices to correct for over- or under estimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the member and the client is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to us is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may hold some portion of the amount that a client pays in a variance account, pending settlement with its participating health care providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from a client. Such payable or receivable would be eventually exhausted by health care provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require Host Blues either (i) to use a basis for determining member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, we would then calculate member liability and the client's liability in accordance with applicable law.

RETURN OF OVERPAYMENTS

Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs Policies, which generally require correction on a claim-by-claim or prospective basis.

Unless otherwise agreed to by the Host Blue, we may request adjustments from the Host Blue for full refunds from healthcare providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with Host Blue's state law or healthcare provider contracts or would jeopardize its relationship with tis health care providers.

BLUECARD PROGRAM FEES AND COMPENSATION

The client understands and agrees to reimburse Highmark Blue Cross Blue Shield for certain fees and compensation which we are obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any accounts. Such revisions typically are made annually as a result of program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with a client's benefit period under this agreement.

Benefit Grids

City of Jamestown PPO 800 $400/$800 MM Ded 0T02
Groups - 10756435, -41, -47

On the chart below, you'll see what you pay for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Hospital	Medical/Surgical	Major Medical
General Provisions			
Effective Date	January 1, 2026		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) Individual Family	 None None	 None None	 $500 $1000
Deductible Accumulation (2)	Not applicable	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Covered in full	Covered in full	10% after deductible
Out-of-Pocket Maximum (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses). Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 None None	 None None	 $6,600 $13,200
Out-of-Pocket Accumulation (2)	Not applicable	Not applicable	Embedded
Office/Urgent Care Visits			
Primary Care Provider Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Specialist Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Virtual Visit Provider Originating Site Fee	not covered	not covered	10% after deductible
Urgent Care Center Visits	covered in full	covered in full	not covered
Telemedicine Services (3)	not covered	not covered	10% after deductible
Preventive Care (4)			
Routine Adult Physical Exams	 covered in full	 covered in full	 covered in full
Adult Immunizations	covered in full	covered in full	covered in full
Routine Gynecological Exams	covered in full	covered in full	covered in full
Routine Pap Smear	covered in full	covered in full	covered in full
Mammograms, Annual Routine	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Routine Pediatric Physical Exams	 covered in full	 covered in full	 covered in full
Pediatric Immunizations	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Emergency Services			
Emergency Medical	covered in full (facility)	covered in full	10% after deductible (physicians)
Ambulance - Emergency and Non-Emergency	not covered	covered in full	not covered
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	covered in full Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy. Major Medical after basic days are exhausted.	covered in full	10% after deductible (MM after basic days are exhausted)
Outpatient Surgery	covered in full	covered in full	not covered
Maternity (non-preventive professional services)	not covered	covered in full	not covered
Medical Care (including inpatient visits and consultations)	not covered	covered in full	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Therapy and Rehabilitation Services			
Physical Therapy	not covered	not covered	10% after deductible
Speech Therapy	not covered	not covered	10% after deductible
Occupational Therapy	not covered	not covered	10% after deductible
Respiratory Therapy	not covered	not covered	10% after deductible
Spinal Manipulations	not covered	not covered	10% after deductible
Cardiac Rehabilitation Therapy	not covered	not covered	10% after deductible
Infusion Therapy	not covered	not covered	10% after deductible
Chemotherapy	covered in full (administration)	covered in full (administration)	10% after deductible (chemo drugs)
Radiation Therapy	covered in full	not covered	10% after deductible
Dialysis	not covered	not covered	10% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	covered in full	covered in full	not covered
Inpatient Substance Abuse Detoxification	covered in full	covered in full	not covered
Inpatient Substance Abuse Rehabilitation	covered in full	covered in full	not covered
Outpatient Mental Health Services (includes virtual behavioral health visits)	not covered	not covered	10% after deductible
Outpatient Substance Abuse Services	not covered	not covered	10% after deductible
Other Services			
Allergy Extracts	not covered	not covered	10% after deductible
Allergy Injections	not covered	not covered	10% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	not covered	not covered	not covered
Assisted Fertilization Procedures	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)
Dental Services Related to Accidental Injury	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	not covered	not covered	10% after deductible
Standard Imaging	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram, Balance under MM	10% after deductible
Diagnostic Medical	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	10% after deductible
Pathology/Laboratory	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	10% after deductible
Allergy Testing	not covered	not covered	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Mammograms, Medically Necessary	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	10% after deductible
Durable Medical Equipment and Supplies	not covered	not covered; $25 copay for diabetic supplies	10% after deductible for DME and diabetic equipment
Orthotics– arch supports are not covered	not covered	not covered	10% after deductible
Prosthetic Devices	covered in full (internal)	not covered	10% after deductible (external)
Home Health Care	not covered	not covered	10% after deductible ; benefit maximum of 40 visits/benefit period aggregate with visiting nurse
Hospice	not covered	not covered	10% after deductible
Infertility Counseling, Testing and Treatment	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	not covered	not covered	10% after deductible ; benefit maximum of 145 days/benefit period
Transplant Services	not covered	not covered	10% after deductible
Prescription Drugs			
Prescription Drug Deductible Individual Family	none none		
Prescription Drug Program (5) Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30/60/90-day Supply)** $8 / $16 / $24 Formulary & Non-Formulary generic copay $40 / $80 / $120 Formulary brand copay $65 / $130 / $195 Non-Formulary brand copay **Select Specialty Drugs (31-day Supply)** $8 Formulary & Non-Formulary generic copay $40 Formulary brand copay $65 Non-Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $8 / $16 / $16 Formulary & Non-Formulary generic copay $40 / $80 / $80 Formulary brand copay $65 / $130 / $130 Non-Formulary brand copay		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

Signature of Client Representative _____ Title _____ Date _____

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Telemedicine Services must be performed by the Highmark Blue Cross Blue Shield Designated Telemedicine Vendor.
(4) Services are limited to those listed on the Highmark NY Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).
(5) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every

major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

City of Jamestown PPO 800 $200/$400 MM Ded 0T04
Groups - 10756436, 42, 48

On the chart below, you'll see what you pay for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Hospital	Medical/Surgical	Major Medical
General Provisions			
Effective Date	January 1, 2026		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) Individual Family	 None None	 None None	 $200 $400
Deductible Accumulation (2)	Not applicable	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Covered in full	Covered in full	10% after deductible
Out-of-Pocket Maximum (Includes coinsurance, deductible and prescription drug cost sharing. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 None None	 $6,600 $13,200
Out-of-Pocket Accumulation (2)	Not applicable	Not applicable	Embedded
Office/Urgent Care Visits			
Primary Care Provider Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Specialist Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Virtual Visit Provider Originating Site Fee	not covered	not covered	10% after deductible
Urgent Care Center Visits	covered in full	not covered	not covered
Telemedicine Services (3)	not covered	not covered	10% after deductible
Preventive Care (4)			
Routine Adult Physical Exams	 covered in full	 covered in full	 covered in full
Adult Immunizations	covered in full	covered in full	covered in full
Routine Gynecological Exams	covered in full	covered in full	covered in full
Routine Pap Smear	covered in full	covered in full	covered in full
Mammograms, Annual Routine	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Routine Pediatric Physical Exams	 covered in full	 covered in full	 covered in full
Pediatric Immunizations	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Emergency Services			
Emergency Medical	covered in full (facility)	covered in full	10% after deductible (physicians)
Ambulance - Emergency and Non-Emergency	not covered	covered in full	not covered
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	covered in full Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy. Major Medical after basic days are exhausted.	covered in full	10% after deductible (MM after basic days are exhausted)
Outpatient Surgery	covered in full	covered in full	not covered
Maternity (non-preventive professional services) including dependent daughters	not covered	covered in full	not covered
Medical Care (including inpatient visits and consultations)	not covered	covered in full	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Therapy and Rehabilitation Services			
Physical Therapy	not covered	not covered	10% after deductible
Speech Therapy	not covered	not covered	10% after deductible
Occupational Therapy	not covered	not covered	10% after deductible
Respiratory Therapy	not covered	not covered	10% after deductible
Spinal Manipulations	not covered	not covered	10% after deductible
Cardiac Rehabilitation Therapy	not covered	not covered	10% after deductible
Infusion Therapy	not covered	not covered	10% after deductible
Chemotherapy	covered in full (administration)	covered in full (administration)	10% after deductible (chemo drugs)
Radiation Therapy	not covered	not covered	10% after deductible
Dialysis	not covered	not covered	10% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	covered in full	covered in full	not covered
Inpatient Substance Abuse Detoxification	covered in full	covered in full	not covered
Inpatient Substance Abuse Rehabilitation	covered in full	covered in full	not covered
Outpatient Mental Health Services (includes virtual behavioral health visits)	not covered	not covered	10% after deductible
Outpatient Substance Abuse Services	not covered	not covered	10% after deductible
Other Services			
Allergy Extracts	not covered	not covered	10% after deductible
Allergy Injections	not covered	not covered	10% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	not covered	not covered	not covered
Assisted Fertilization Procedures In-Vitro Fertilization and Fertility Preservation is not covered	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)
Dental Services Related to Accidental Injury	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	not covered	not covered	10% after deductible
Standard Imaging	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram, Balance under MM	10% after deductible
Diagnostic Medical	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	10% after deductible
Pathology/Laboratory	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	10% after deductible
Allergy Testing	not covered	not covered	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Mammograms, Medically Necessary	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	10% after deductible
Durable Medical Equipment and Supplies	not covered	not covered; $25 copay for diabetic supplies	10% after deductible for DME and diabetic equipment
Orthotics – arch supports are not covered	not covered	not covered	10% after deductible
Prosthetic Devices	covered in full (internal)	not covered	10% after deductible (external)
Home Health Care	not covered	not covered	10% after deductible ; benefit maximum of 40 visits/benefit period aggregate with visiting nurse
Hospice	not covered	not covered	10% after deductible
Infertility Counseling, Testing and Treatment	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	not covered	not covered	10% after deductible Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy
Transplant Services	not covered	not covered	10% after deductible
Prescription Drugs			
Prescription Drug Deductible Individual Family	none none		
Prescription Drug Program (5) Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30/60/90-day Supply)** $10 / $20 / $30 Formulary & Non-Formulary generic copay $20 / $40 / $60 Formulary brand copay $40 / $80 / $120 Non-Formulary brand copay **Select Specialty Drugs (31-day Supply)** $10 Formulary & Non-Formulary generic copay $20 Formulary brand copay $40 Non-Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $10 / $20 / $20 Formulary & Non-Formulary generic copay $20 / $40 / $40 Formulary brand copay $40 / $80 / $80 Non-Formulary brand copay		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

Signature of Client Representative _____ Title _____ Date _____

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Telemedicine Services must be performed by the Highmark Blue Cross Blue Shield Designated Telemedicine Vendor.
(4) Services are limited to those listed on the Highmark NY Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).

(5) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

City of Jamestown PPO 800 $200/$400 MM Ded 0T05
Groups - 10756437, 43, 49

On the chart below, you'll see what you pay for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Hospital	Medical/Surgical	Major Medical
General Provisions			
Effective Date	January 1, 2026		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) Individual Family	 None None	 None None	 $200 $400
Deductible Accumulation (2)	Not applicable	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Covered in full	Covered in full	10% after deductible
Out-of-Pocket Maximum (Includes coinsurance and deductible. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 None None	 $6,600 $13,200
Out-of-Pocket Accumulation (2)	Not applicable	Not applicable	Embedded
Office/Urgent Care Visits			
Primary Care Provider Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Specialist Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Virtual Visit Provider Originating Site Fee	not covered	not covered	10% after deductible
Urgent Care Center Visits	covered in full	not covered	not covered
Telemedicine Services (3)	not covered	not covered	10% after deductible
Preventive Care (4)			
Routine Adult Physical Exams	covered in full	covered in full	covered in full
Adult Immunizations	covered in full	covered in full	covered in full
Routine Gynecological Exams	covered in full	covered in full	covered in full
Routine Pap Smear	covered in full	covered in full	covered in full
Mammograms, Annual Routine	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Routine Pediatric Physical Exams	covered in full	covered in full	covered in full
Pediatric Immunizations	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Emergency Services			
Emergency Medical	covered in full (facility)	covered in full	10% after deductible (physicians)
Ambulance - Emergency and Non-Emergency	not covered	covered in full	not covered
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	covered in full	covered in full	10% after deductible (MM after basic days are exhausted)
	Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy. Major Medical after basic days are exhausted.		
Outpatient Surgery	covered in full	covered in full	not covered
Maternity (non-preventive professional services) including dependent daughters	not covered	covered in full	not covered
Medical Care (including inpatient visits and consultations)	not covered	covered in full	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Therapy and Rehabilitation Services			
Physical Therapy	not covered	not covered	10% after deductible
Speech Therapy	not covered	not covered	10% after deductible
Occupational Therapy	not covered	not covered	10% after deductible
Respiratory Therapy	not covered	not covered	10% after deductible
Spinal Manipulations	not covered	not covered	10% after deductible
Cardiac Rehabilitation Therapy	not covered	not covered	10% after deductible
Infusion Therapy	not covered	not covered	10% after deductible
Chemotherapy	covered in full (administration)	covered in full (administration)	10% after deductible (chemo drugs)
Radiation Therapy	not covered	not covered	10% after deductible
Dialysis	not covered	not covered	10% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	covered in full	covered in full	not covered
Inpatient Substance Abuse Detoxification	covered in full	covered in full	not covered
Inpatient Substance Abuse Rehabilitation	covered in full	covered in full	not covered
Outpatient Mental Health Services (includes virtual behavioral health visits)	not covered	not covered	10% after deductible
Outpatient Substance Abuse Services	not covered	not covered	10% after deductible
Other Services			
Allergy Extracts	not covered	not covered	10% after deductible
Allergy Injections	not covered	not covered	10% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	not covered	not covered	not covered
Assisted Fertilization Procedures In-Vitro Fertilization and Fertility Preservation is not covered	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)
Dental Services Related to Accidental Injury	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	not covered	not covered	10% after deductible
Standard Imaging	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram, Balance under MM	10% after deductible
Diagnostic Medical	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	10% after deductible
Pathology/Laboratory	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	10% after deductible
Allergy Testing	not covered	not covered	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Mammograms, Medically Necessary	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	10% after deductible
Durable Medical Equipment and Supplies	not covered	not covered; $25 copay for diabetic supplies	10% after deductible for DME and diabetic equipment
Orthotics – arch supports are not covered	not covered	not covered	10% after deductible
Prosthetic Devices	covered in full (internal)	not covered	10% after deductible (external)
Home Health Care	not covered	not covered	10% after deductible ; benefit maximum of 40 visits/benefit period aggregate with visiting nurse
Hospice	not covered	not covered	10% after deductible
Infertility Counseling, Testing and Treatment	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	not covered	not covered	10% after deductible Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy
Transplant Services	not covered	not covered	10% after deductible
Prescription Drugs			
Prescription Drug Deductible Individual Family	none none		
Prescription Drug Program (5) Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30/60/90-day Supply)** $10 / $20 / $30 Formulary & Non-Formulary generic copay $20 / $40 / $60 Formulary brand copay $40 / $80 / $120 Non-Formulary brand copay **Select Specialty Drugs (31-day Supply)** $10 Formulary & Non-Formulary generic copay $20 Formulary brand copay $40 Non-Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $10 / $20 / $20 Formulary & Non-Formulary generic copay $20 / $40 / $40 Formulary brand copay $40 / $80 / $80 Non-Formulary brand copay		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

Signature of Client Representative _____ Title _____ Date _____

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Telemedicine Services must be performed by the Highmark Blue Cross Blue Shield Designated Telemedicine Vendor.
(4) Services are limited to those listed on the Highmark NY Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).

(5) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

City of Jamestown PPO 800 $400/$800 MM Ded 0T06
Groups - 10756438, 44, 50

On the chart below, you'll see what you pay for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Hospital	Medical/Surgical	Major Medical
General Provisions			
Effective Date	January 1, 2026		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) Individual Family	 None None	 None None	 $400 $800
Deductible Accumulation (2)	Not applicable	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Covered in full	Covered in full	10% after deductible
Out-of-Pocket Maximum (Includes coinsurance and deductible. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 None None	 $6,600 $13,200
Out-of-Pocket Accumulation (2)	Not applicable	Not applicable	Embedded
Office/Urgent Care Visits			
Primary Care Provider Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Specialist Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Virtual Visit Provider Originating Site Fee	not covered	not covered	10% after deductible
Urgent Care Center Visits	covered in full	not covered	not covered
Telemedicine Services (3)	not covered	not covered	10% after deductible
Preventive Care (4)			
Routine Adult Physical Exams	covered in full	covered in full	covered in full
Adult Immunizations	covered in full	covered in full	covered in full
Routine Gynecological Exams	covered in full	covered in full	covered in full
Routine Pap Smear	covered in full	covered in full	covered in full
Mammograms, Annual Routine	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Routine Pediatric Physical Exams	covered in full	covered in full	covered in full
Pediatric Immunizations	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Emergency Services			
Emergency Medical	covered in full (facility)	covered in full	10% after deductible (physicians)
Ambulance - Emergency and Non-Emergency	not covered	covered in full	not covered
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	covered in full	covered in full	10% after deductible (MM after basic days are exhausted)
	Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy. Major Medical after basic days are exhausted.		
Outpatient Surgery	covered in full	covered in full	not covered
Maternity (non-preventive professional services) including dependent daughters	not covered	covered in full	not covered
Medical Care (including inpatient visits and consultations)	not covered	covered in full	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Therapy and Rehabilitation Services			
Physical Therapy	not covered	not covered	10% after deductible
Speech Therapy	not covered	not covered	10% after deductible
Occupational Therapy	not covered	not covered	10% after deductible
Respiratory Therapy	not covered	not covered	10% after deductible
Spinal Manipulations	not covered	not covered	10% after deductible
Cardiac Rehabilitation Therapy	not covered	not covered	10% after deductible
Infusion Therapy	covered in full	not covered	10% after deductible
Chemotherapy	covered in full (administration)	covered in full (administration)	10% after deductible (chemo drugs)
Radiation Therapy	not covered	not covered	10% after deductible
Dialysis	not covered	not covered	10% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	covered in full	covered in full	not covered
Inpatient Substance Abuse Detoxification	covered in full	covered in full	not covered
Inpatient Substance Abuse Rehabilitation	covered in full	covered in full	not covered
Outpatient Mental Health Services (includes virtual behavioral health visits)	not covered	not covered	10% after deductible
Outpatient Substance Abuse Services	not covered	not covered	10% after deductible
Other Services			
Allergy Extracts	not covered	not covered	10% after deductible
Allergy Injections	not covered	not covered	10% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	not covered	not covered	not covered
Assisted Fertilization Procedures In-Vitro Fertilization and Fertility Preservation is not covered	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Dental Services Related to Accidental Injury	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	not covered	not covered	10% after deductible
Standard Imaging	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram, Balance under MM	10% after deductible
Diagnostic Medical	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	10% after deductible
Pathology/Laboratory	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	10% after deductible
Allergy Testing	not covered	not covered	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Mammograms, Medically Necessary	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	10% after deductible
Durable Medical Equipment and Supplies	not covered	not covered; $25 copay for diabetic supplies	10% after deductible for DME and diabetic equipment
Orthotics	not covered	not covered	10% after deductible
Prosthetic Devices	covered in full (internal)	not covered	10% after deductible (external)
Home Health Care	not covered	not covered	10% after deductible benefit maximum of 40 visits/benefit period aggregate with visiting nurse
Hospice	not covered	not covered	10% after deductible
Infertility Counseling, Testing and Treatment	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	not covered	not covered	10% after deductible Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy
Transplant Services	not covered	not covered	10% after deductible
Prescription Drugs			
Prescription Drug Deductible Individual Family	none none		
Prescription Drug Program (5) Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30/60/90-day Supply)** $8 / $16 / $24 Formulary & Non-Formulary generic copay $40 / $80 / $120 Formulary brand copay $65 / $130 / $195 Non-Formulary brand copay **Select Specialty Drugs (31-day Supply)** $8 Formulary & Non-Formulary generic copay $40 Formulary brand copay $65 Non-Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $8 / $16 / $16 Formulary & Non-Formulary generic copay $40 / $80 / $80 Formulary brand copay $65 / $130 / $130 Non-Formulary brand copay		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

Signature of Client Representative _____ Title _____ Date _____

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Telemedicine Services must be performed by the Highmark Blue Cross Blue Shield Designated Telemedicine Vendor.
(4) Services are limited to those listed on the Highmark NY Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).

(5) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

City of Jamestown PPO 800 $500/$1000 MM Ded 0T07
Groups - 10756439, 45, 51

On the chart below, you'll see what you pay for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Hospital	Medical/Surgical	Major Medical
General Provisions			
Effective Date	January 1, 2026		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) Individual Family	 None None	 None None	 $500 $1,000
Deductible Accumulation (2)	Not applicable	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Covered in full	Covered in full	10% after deductible
Out-of-Pocket Maximum (Includes coinsurance and deductible. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 None None	 $6,600 $13,200
Out-of-Pocket Accumulation (2)	Not applicable	Not applicable	Embedded
Office/Urgent Care Visits			
Primary Care Provider Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Specialist Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Virtual Visit Provider Originating Site Fee	not covered	not covered	10% after deductible
Urgent Care Center Visits	covered in full	not covered	not covered
Telemedicine Services (3)	not covered	not covered	10% after deductible
Preventive Care (4)			
Routine Adult Physical Exams	 covered in full	 covered in full	 covered in full
Adult Immunizations	covered in full	covered in full	covered in full
Routine Gynecological Exams	covered in full	covered in full	covered in full
Routine Pap Smear	covered in full	covered in full	covered in full
Mammograms, Annual Routine	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Routine Pediatric Physical Exams	 covered in full	 covered in full	 covered in full
Pediatric Immunizations	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Emergency Services			
Emergency Medical	covered in full (facility)	covered in full	10% after deductible (physicians)
Ambulance - Emergency and Non-Emergency	not covered	covered in full	not covered
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	covered in full Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy. Major Medical after basic days are exhausted.	covered in full	10% after deductible (MM after basic days are exhausted)
Outpatient Surgery	covered in full	covered in full	not covered
Maternity (non-preventive professional services) including dependent daughter	not covered	covered in ful	not covered
Medical Care (including inpatient visits and consultations)	not covered	covered in full	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Therapy and Rehabilitation Services			
Physical Therapy	not covered	not covered	10% after deductible
Speech Therapy	not covered	not covered	10% after deductible
Occupational Therapy	not covered	not covered	10% after deductible
Respiratory Therapy	not covered	not covered	10% after deductible
Spinal Manipulations	not covered	not covered	10% after deductible
Cardiac Rehabilitation Therapy	not covered	not covered	10% after deductible
Infusion Therapy	not covered	not covered	10% after deductible
Chemotherapy	covered in full (administration)	covered in full (administration)	10% after deductible (chemo drugs)
Radiation Therapy	not covered	not covered	10% after deductible
Dialysis	not covered	not covered	10% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	covered in full	covered in full	not covered
Inpatient Substance Abuse Detoxification	covered in full	covered in full	not covered
Inpatient Substance Abuse Rehabilitation	covered in full	covered in full	not covered
Outpatient Mental Health Services (includes virtual behavioral health visits)	not covered	not covered	10% after deductible
Outpatient Substance Abuse Services	not covered	not covered	10% after deductible
Other Services			
Allergy Extracts	not covered	not covered	10% after deductible
Allergy Injections	not covered	not covered	10% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	covered in full	not covered	not covered
Assisted Fertilization Procedures In-Vitro Fertilization and Fertility Preservation is not covered	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)
Dental Services Related to Accidental Injury	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	not covered	not covered	10% after deductible
Standard Imaging	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram, Balance under MM	10% after deductible
Diagnostic Medical	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	10% after deductible
Pathology/Laboratory	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	10% after deductible
Allergy Testing	not covered	not covered	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Mammograms, Medically Necessary	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	covered in full benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	10% after deductible
Durable Medical Equipment and Supplies	not covered	not covered; $25 copay for diabetic supplies	10% after deductible for DME and diabetic equipment
Orthotics – arch supports are not covered	not covered	not covered	10% after deductible
Prosthetic Devices	covered in full (internal)	not covered	10% after deductible (external)
Home Health Care	not covered	not covered	10% after deductible benefit maximum of 40 visits/benefit period aggregate with visiting nurse
Hospice	not covered	not covered	10% after deductible
Infertility Counseling, Testing and Treatment	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	not covered	not covered	10% after deductible Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy
Transplant Services	covered in full	covered in full	10% after deductible
Prescription Drugs			
Prescription Drug Deductible Individual Family	none none		
Prescription Drug Program (5) Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30/60/90-day Supply)** $8 / $16 / $24 Formulary & Non-Formulary generic copay $40 / $80 / $120 Formulary brand copay $65 / $130 / $195 Non-Formulary brand copay **Select Specialty Drugs (31-day Supply)** $8 Formulary & Non-Formulary generic copay $40 Formulary brand copay $65 Non-Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $8 / $16 / $16 Formulary & Non-Formulary generic copay $40 / $80 / $80 Formulary brand copay $65 / $130 / $130 Non-Formulary brand copay		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

Signature of Client Representative _____ Title _____ Date _____

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Telemedicine Services must be performed by the Highmark Blue Cross Blue Shield Designated Telemedicine Vendor.
(4) Services are limited to those listed on the Highmark NY Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).

(5) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

City of Jamestown PPO 800 $500/$1000 MM Ded 0T08
Groups - 10772338, 10756446, 52

On the chart below, you'll see what you pay for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Hospital	Medical/Surgical	Major Medical
General Provisions			
Effective Date	January 1, 2026		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) Individual Family	 None None	 None None	 $500 $1,000
Deductible Accumulation (2)	Not applicable	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Covered in full	Covered in full	10% after deductible
Out-of-Pocket Maximum (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses). Once met, the plan pays 100% of covered services for the rest of the benefit period.) Individual Family	 None None	 None None	 $6,600 $13,200
Out-of-Pocket Accumulation (2)	Not applicable	Not applicable	Embedded
Office/Urgent Care Visits			
Primary Care Provider Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Specialist Office Visits & Virtual Visits	not covered	not covered	10% after deductible
Virtual Visit Provider Originating Site Fee	not covered	not covered	10% after deductible
Urgent Care Center Visits	covered in full	covered in full	not covered
Telemedicine Services (3)	not covered	not covered	10% after deductible
Preventive Care (4)			
Routine Adult Physical Exams	 covered in full	 covered in full	 covered in full
Adult Immunizations	covered in full	covered in full	covered in full
Routine Gynecological Exams	covered in full	covered in full	covered in full
Routine Pap Smear	covered in full	covered in full	covered in full
Mammograms, Annual Routine	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Routine Pediatric Physical Exams	 covered in full	 covered in full	 covered in full
Pediatric Immunizations	covered in full	covered in full	covered in full
Diagnostic Services and Procedures	covered in full	covered in full	covered in full
Emergency Services			
Emergency Medical	covered in full (facility)	covered in full	10% after deductible (physicians)
Ambulance - Emergency and Non-Emergency	not covered	covered in full	not covered
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	covered in full	covered in full	10% after deductible (MM after basic days are exhausted)
	Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy. Major Medical after basic days are exhausted		
Outpatient Surgery	covered in full	covered in full	not covered
Maternity (non-preventive professional services) including dependent daughter	not covered	covered in full	not covered
Medical Care (including inpatient visits and consultations)	not covered	covered in full	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Therapy and Rehabilitation Services			
Physical Therapy	not covered	not covered	10% after deductible
Speech Therapy	not covered	not covered	10% after deductible
Occupational Therapy	not covered	not covered	10% after deductible
Respiratory Therapy	not covered	not covered	10% after deductible
Spinal Manipulations	not covered	not covered	10% after deductible
Cardiac Rehabilitation Therapy	not covered	not covered	10% after deductible
Infusion Therapy	covered in full	not covered	10% after deductible
Chemotherapy	covered in full (administration)	covered in full (administration)	10% after deductible (chemo drugs)
Radiation Therapy	not covered	not covered	10% after deductible
Dialysis	not covered	not covered	10% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	covered in full	covered in full	not covered
Inpatient Substance Abuse Detoxification	covered in full	covered in full	not covered
Inpatient Substance Abuse Rehabilitation	covered in full	covered in full	not covered
Outpatient Mental Health Services (includes virtual behavioral health visits)	not covered	not covered	10% after deductible
Outpatient Substance Abuse Services	not covered	not covered	10% after deductible
Other Services			
Allergy Extracts	not covered	not covered	10% after deductible
Allergy Injections	not covered	not covered	10% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	not covered	not covered	not covered
Assisted Fertilization Procedures (GIFT & ZIFT excluded)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Dental Services Related to Accidental Injury	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	not covered	not covered	10% after deductible
Standard Imaging	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with pathology/laboratory diagnostic medical and diagnostic mammogram, Balance under MM	10% after deductible
Diagnostic Medical	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic mammogram Balance under MM	10% after deductible
Pathology/Laboratory	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	covered in full Benefit maximum of $300/benefit period aggregate with standard imaging diagnostic medical and diagnostic mammogram Balance under MM	10% after deductible
Allergy Testing	not covered	not covered	10% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Mammograms, Medically Necessary	covered in full: benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	covered in full: benefit maximum of $300/benefit period aggregate with standard imaging pathology/laboratory and diagnostic medical. Balance under MM.	10% after deductible
Durable Medical Equipment and Supplies	not covered	not covered; $25 copay for diabetic supplies	10% after deductible for DME and diabetic equipment
Orthotics - arch supports are not covered	not covered	not covered	10% after deductible
Prosthetic Devices	covered in full (internal)	not covered	10% after deductible (external)
Home Health Care	not covered	not covered	10% after deductible benefit maximum of 40 visits/benefit period aggregate with visiting nurse
Hospice	not covered	not covered	10% after deductible
Infertility Counseling, Testing and Treatment	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)	See service category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	not covered	not covered	10% after deductible Benefit maximum of 145 days/benefit period aggregate with short term inpatient rehabilitation therapy
Transplant Services	not covered	not covered	10% after deductible
Prescription Drugs			
Prescription Drug Deductible Individual Family	none none		
Prescription Drug Program (5) Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30/60/90-day Supply)** $8 / $16 / $24 Formulary & Non-Formulary generic copay $40 / $80 / $120 Formulary brand copay $65 / $130 / $195 Non-Formulary brand copay **Select Specialty Drugs (31-day Supply)** $8 Formulary & Non-Formulary generic copay $40 Formulary brand copay $65 Non-Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $8 / $16 / $16 Formulary & Non-Formulary generic copay $40 / $80 / $80 Formulary brand copay $65 / $130 / $130 Non-Formulary brand copay		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

Signature of Client Representative _____ Title _____ Date _____

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Telemedicine Services must be performed by the Highmark Blue Cross Blue Shield Designated Telemedicine Vendor.
(4) Services are limited to those listed on the Highmark NY Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).

(5) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

City of Jamestown PPO 200D - 0T09
Groups - 10661736, 43, 50

On the chart below, you'll see what you pay for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2026	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $500 $1,000	 $1,500 $3,000
Deductible Accumulation (2)	Embedded	Embedded
Coinsurance - payment based on the plan allowance	10% after deductible	30% after deductible
Out-of-Pocket Maximum (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses). Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $1,500 $3,000	 $10,000 $20,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	$25 copay	30% after deductible
Specialist Office Visits & Virtual Visits	$25 copay	30% after deductible
Virtual Visit Provider Originating Site Fee	covered in full	30% after deductible
Urgent Care Center Visits	$50 copay	$50 copay
Telemedicine Services (3)	$25 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 covered in full	 not covered
Adult Immunizations	covered in full	30% after deductible
Routine Gynecological Exams, including a Pap Test	covered in full	30% after deductible
Mammograms, Annual Routine	covered in full	30% after deductible
Diagnostic Services and Procedures	covered in full	30% after deductible
Routine Pediatric Physical Exams	 covered in full	 30% after deductible
Pediatric Immunizations	covered in full	30% after deductible
Diagnostic Services and Procedures	covered in full	30% after deductible
Emergency Services		
Emergency Room Services (5)	$50 copay (waived if admitted) after in-network deductible; $50 copay for freestanding urgent care facility after in-network deductible	
Ambulance - Emergency and Non-Emergency	$50 copay after deductible	$50 copay after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	10% after deductible; Waive coinsurance after deductible for maternity admission	30% after deductible
Outpatient Surgery	10% after deductible	30% after deductible
Maternity (non-preventive professional services) including dependent daughters	$25 copay on initial visit only	30% after deductible
Medical Care (including inpatient visits and consultations)	10% after deductible	30% after deductible
Therapy and Rehabilitation Services		
Physical Therapy	10% after deductible limit: 20 visits/benefit period	30% after deductible
Speech Therapy	10% after deductible limit: 20 visits/benefit period	30% after deductible
Occupational Therapy	10% after deductible limit: 20 visits/benefit period	30% after deductible

Benefit	In Network	Out of Network
Respiratory Therapy	10% (deductible does not apply)	30% after deductible
Spinal Manipulations	$25 copay	30% after deductible
Cardiac Rehabilitation Therapy	10% after deductible	30% after deductible
	limit: 24 visits/benefit period	
Infusion Therapy	$25 copay; covered in full for home infusion therapy	30% after deductible; 30% after deductible for home infusion therapy
Chemotherapy	10% after deductible	30% after deductible
Radiation Therapy	10% (deductible does not apply)	30% after deductible
Dialysis	10% after deductible; covered in full for home dialysis	30% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	10% after deductible	30% after deductible
Inpatient Detoxification / Rehabilitation	10% after deductible	30% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	covered in full	30% after deductible
Outpatient Substance Abuse Services	covered in full	30% after deductible
Other Services		
Allergy Extracts	covered in full	30% after deductible
Allergy Injections	$25 copay	30% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	not covered	not covered
Assisted Fertilization Procedures - In-Vitro Fertilization and Fertility Preservation is not covered	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Dental Services Related to Accidental Injury	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	10% after deductible	30% after deductible
Standard Imaging	10% after deductible	30% after deductible
Diagnostic Medical	10% (deductible does not apply)	30% after deductible
Pathology/Laboratory	10% after deductible	30% after deductible
Allergy Testing	$25 copay	30% after deductible
Mammograms, Medically Necessary	$25 copay	30% after deductible
Durable Medical Equipment and Supplies	50% after deductible; $25 copay for diabetic equipment and diabetic supplies	50% after deductible; 30% after deductible for diabetic equipment and supplies
Orthotics	50% after deductible	50% after deductible
Prosthetic Devices	10% (deductible does not apply) for implantable prosthetics; 50% after deductible for external prosthetics	30% after deductible for internal; 50% after deductible for external prosthetics
Home Health Care	$25 copay	30% after deductible
Hospice	10% after deductible	30% after deductible
Infertility Counseling, Testing and Treatment	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	10% after deductible	30% after deductible
	limit: 50 days/benefit period	
Transplant Services	10% after deductible	30% after deductible
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (6) Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30/60/90-day Supply)** $7 / $14 / $21 Formulary generic copay $7 / $14 / $21 Non-Formulary generic copay $40 / $80 / $120 Formulary brand copay $65 / $130 / $195 Non-Formulary brand copay **Select Specialty Drugs (31-day Supply)** $7 Formulary generic copay	

Benefit	In Network	Out of Network
	$7 Non-Formulary generic copay $40 Formulary brand copay $65 Non-Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $7 / $14 / $14 Formulary generic copay $7 / $14 / $14 Non-Formulary generic copay $40 / $80 / $80 Formulary brand copay $65 / $130 / $130 Non-Formulary brand copay	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

Signature of Client Representative _____ Title _____ Date _____

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Telemedicine Services must be performed by the Highmark Blue Cross Blue Shield Designated Telemedicine Vendor.
(4) Services are limited to those listed on the Highmark NY Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee hane´é biká'ïgíí bich´j´dahodootnih.

11699_09_21

Vision Benefits for Large Groups
Affinity Discount Program

Benefits	Member Cost
Services	
Eye exam	$0 cost-share
Frames	
Frames	35% discount off retail
Lens (uncoated plastic)	
Single vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
Lens Options (add to lens prices above)	
Antireflective coating (premium)	20% discount off retail
Antireflective coating (standard)	$45
Blended segment lenses	$20
Glass lenses	$18
Gradient tint	$12
Hi-index lenses	$55
Photochromic glass lenses (single vision)	$35
Photochromic glass lenses (multifocal)	$35
Polarized lenses	$75
Solid tint	$10
Standard scratch-resistant	$15
Standard polycarbonate	$30
Standard progressive (add-on to bifocal)	$75
Transition lenses	$65
UV coating	$15
Contact Lens (available in lieu of spectacles)	
Conventional/disposable/planned replacement	15% discount off retail
Other Add-ons and Services	
Nonprescription sunglasses	10–20% discount off retail
Other ancillary products/solutions	10–20% discount off retail
Laser Vision Correction	
Laser vision correction procedure	Up to 40–50% discount off retail
Frequency	
Examination	Annual
Frames	Unlimited
Lenses	Unlimited
Contact lenses	Unlimited

Davis Vision, an independent company, administers vision benefits on behalf of Highmark Blue Cross Blue Shield. Members must receive services from a Davis Vision provider. Appropriate discounts[1] are taken at time of purchase (first purchase of eyeglasses is subject to a 35% discount; additional eyeglass purchases are subject to a 30% discount on the same transaction; additional eyeglass purchases on separate transactions are subject to a 20% discount). Services out-of-network are not covered. For more information on the Laser Vision Correction Discount Program available through Davis Vision, call 1-800-999-5431. To locate a provider near you, visit **myhighmark.com**, **davisvision.com**, or contact Davis Vision at 1-800-999-5431.

1. Discounts not applicable at Walmart®, Sam's Club, or Costco locations or where limited by law or manufacturer restrictions.
2. Contact lens coverage varies by product selection.
3. Provider promotions and/or discounts may not be combined with insurance benefits or discounts.
4. Some limitations apply to additional discounts; discounts not applicable at all in-network providers. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

No benefits shall be provided for:

- Vision services received or prescribed before the effective date of coverage or ordered after termination of coverage
- Examinations, frames, or lenses that are not necessary according to accepted standards of ophthalmic practice or that are not prescribed by the attending physician or by the optometrist
- Replacement of lost, stolen, broken, or damaged lenses, contact lenses, or frames, unless at the time of replacement the subscriber is otherwise entitled to benefits for the lenses for frames

- Industrial safety glasses, safety goggles, or sunglasses, whether or not they require a prescription
- Examinations, frames, or lenses required by the subscriber's employment
- Duplication of services: the benefits covered under this amendment are reduced by any benefits received under your contract or group plan

Highmark Blue Cross Blue Shield is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

Highmark Blue Cross Blue Shield complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-544-2583 (TTY 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-544-2583 (TTY 711)。

HIGHMARK

City of Jamestown

Summary of Multiple-Year Administrative Services Only Administrative Fees

Summary of Terms:

Average # of Contracts: **403** Average # of Members: **937**

The administrative fees shall be an amount as follows:

Administrative Fees Expressed as $ per Contract Holder per Month			
	01/01/2026	01/01/2027	01/01/2028
Medical Program	$47.55 PCPM	$48.05 PCPM	$48.55 PCPM
Producer Commission	PCPM	PCPM	PCPM
Loyalty Discount[3]	$85,000.00	$40,000.00	$20,000.00

Retail - Guaranteed Discounts	
Network	National Plus
Brand 30	AWP- 19.75%
Brand 90	AWP- 22.75%
Generic 30	AWP- 84.25%
Generic 90	AWP- 84.25%
Dispensing Fees	$0.75 per Claim
Mail - Guaranteed Discounts	
Brand	AWP- 25.00%
Generic	AWP- 87.00%
Dispensing Fees	$0.75 per Claim
Specialty Option 1 - Guaranteed Discounts	
Specialty Pharmacy Program with Free Market Health	AWP- 22.00%
Dispensing Fees	$0.00 per Claim
Specialty Option 2 – Guaranteed Dicsounts	
Accredo Exclusive	AWP- 21.50%
Dispensing Fee	$0.00 per Claim
Open Specialty Network	AWP- 19.00%
Dispensing Fees	$0.75 per Claim
Rebates Option 1	
Comprehensive Formulary	
Arrangement	100% Pass-Through
Retail Brand 30 Script	$423.21
Retail Brand 90 Script	$1,295.48
Mail Brand Script	$1,295.48
Specialty Brand Script	$6,325.56
Accepted	(Yes)/No
Rebates Option 2	
National Select Formulary	
Arrangement	100% Pass-Through
Retail Brand 30 Script	$465.53
Retail Brand 90 Script	$1,425.03
Mail Brand Script	$1,425.03
Specialty Brand Script	$6,958.12
Accepted	Yes/(No)

Credit Payment	
Details	City of Jamestown will receive 100% of the rebates for their membership. The rates above represent the minimum floors. If the total annual value of the rebates does not meet these, Highmark will pay the client the shortfall. If the total annual value exceeds these, the client will retain that amount.
Administrative Fee	
Base Admin Fee	Without Truveris: $3.25 Per Script ☐ With Truveris: $4.50 Per Script ☐

Rebates earned will be dependent on Weight Loss Coverage and Policy implemented.

In addition to the above administrative fee, a carve-out fee of $4.00 PCPM applies when you select a stop-loss insurance carrier other than an affiliate of the HM Life Insurance Company[4]. This includes standard reports provided for outside stop-loss carrier.

In addition to the above administrative fee, a carve-out fee of $5.00 PCPM applies when you select a pharmacy benefits administrator (PBM) other than Highmark Blue Cross Blue Shield.

Claim Deposit Fund Requirement – Details will be provided separately. Initial deposit held by the company is due prior to claims being processed and paid. Amount due is calculated using a 14-day average claims volume. Initial amount will be billed separately upon group implementation. Claim Deposit Fund amount is subject to change during term and any revised amount is due in accordance with ASO Agreement terms.

Credit payment - Client will receive 100% of the rebates for their membership. The rates above represent the minimum floors. If the total annual value of the rebates does not meet these, Highmark will pay the client the shortfall. If the total annual value exceeds these, the client will retain that amount.

Any excess achieved for any discount guarantee listed or any excess achieved for any other discount guarantee offered pursuant to this Agreement will be used to make up for, and offset, any deficit in any discount guarantee listed in the table above. Rebate guarantees may not offset any discount guarantees.

Discount Exclusions: (1) home host pharmacy Claims; (2) 340B Claims; (3) Compound Drugs; (4) Member submitted Claims or Paper Claims; (5) Secondary Payer Coordination of Benefits (COB)/Subrogation Claims; (6) Long Term Care (LTC) pharmacy Claims, (7) I/T/U claims, (8) Home Infusion Claims; (9) Military and Veterans Pharmacy Claims; (10) Vaccine Claims; (11) Any Claim that is not a Paid Claim, including rejected, adjusted, and/or cancelled claims or claims processed for returned goods.

Rebate Exclusions: (a) 340B claims; (b) Biosimilars; (c) Compound Drugs; (d) Military Pharmacy Claims; (e) Vaccine Claims; (f) COVID Products; (g) Insulin Claims; (h) Limited Distribution Drugs; (i) Non-Specialty Mail Claims less than 84 days; (j) Over-the-Counter (OTC) Products; (k) and any other Non-Drug (Insulin Syringes, Supply, Devices, etc.) Claims.

When remitting and reconciling minimum Rebate guarantees, Highmark may add "Rebate Credit" value to the total Rebates remitted to Sponsor for each respective Rebate component. "Rebate Credits" shall consist of (i) the differential between the Wholesale Acquisition Cost (WAC) of a lower net cost Brand Drug, including but not limited to a Biosimilar ("Low Cost Brand"), Claim processed and the WAC of the reference Brand Drug, subject to the below cap; and/or (ii) the value of price reductions for rebateable products that have experienced a WAC decrease, measured as the differential between the Baseline WAC of the product and the WAC of the product when the Claim is processed, subject to the below cap. The "Baseline WAC" will be the WAC of the product prior to a reduction in WAC or, as applicable, for Low-Cost Brands, the Baseline WAC will be the WAC of the reference Brand Drug at the time of Claim processing.

Rebate guarantees assume application of Rebate Credit for any products added to the Rebate Credit list. Upon thirty (30) days prior written notice to Sponsor, Highmark reserves the right to modify or amend the financial provisions of the agreement to account for the impact of events identified below. Such notice will include Highmark's explanation of the manner in which the modification accounts for the impact of the event.

The specialty drug list is subject to change from time-to-time. Highmark Blue Cross Blue Shield reserves the right to add or delete products, or modify rates/pricing terms in the Specialty Pharmacy Program.

[3]Highmark Blue Cross Blue Shield agrees to discount the above medical/prescription fees in an amount equal to the above in recognition of Sponsor's continued loyalty to Highmark Blue Cross Blue Shield (the Loyalty Discount). Notwithstanding the preceding, if: (i) Sponsor terminates the ASO Agreement before expiration of the period commencing on 01/01/2026 and ending on 12/31/2028 (the ASO Agreement Term); (ii) Highmark Blue Cross Blue Shield terminates the ASO Agreement during the ASO Agreement Term due to Sponsor's failure to timely remit payment for administrative fees or claims costs, then Highmark Blue Cross Blue Shield shall have the right to reconcile Sponsor's administrative fee obligations under the ASO Agreement by retroactively revoking the Loyalty Discount to the first day of the ASO

Agreement Term (the True Up). In furtherance of the True Up, Sponsor shall refund the Loyalty Discount to Highmark Blue Cross Blue Shield not later than ten (10) business days following the date of such event. Sponsor expressly acknowledges and agrees that the administrative fees for the ASO Agreement Term (whether or not the Loyalty Discount is offered/accepted or the True Up is triggered) are financially advantageous to both Sponsor and the Plan; and, furthermore, Sponsor acknowledges that it has had an opportunity to consult with legal advisors prior to accepting the preceding terms and conditions regarding the Loyalty Discount and the True Up.

[4]HM Life Insurance Company is a separate company that does not provide Blue Cross and/or Blue Shield products or services. HM Life Insurance Company is solely responsible for issuing stop-loss insurance coverage.

Accepted by:

Employer Rep _____ Title MAYOR Date 12/05/25

SUPPLEMENT (PART A) TO RENEWAL ACCEPTANCE AGREEMENT

Client Name: City of Jamestown
Client Number: 287748
Renewal Period: 01/01/2026 to 12/31/2026

This Supplement (Part A) to the Renewal Acceptance Agreement includes additional agreed upon terms concerning services and fees that will apply to our administrative services only agreement or claims-billed cost plus insurance contract (Service Agreement) during the above Renewal Period.

The above named group (Client) understands and agrees that the Renewal Acceptance Agreement, Supplement (Part A) and Supplement (Part B) (collectively, the Renewal) supersedes and amends the relevant terms of our Service Agreement. Accordingly, the terms of the Renewal control over any conflicting terms in our Service Agreement.

Please have an authorized representative (Group Representative) accept the terms and conditions of this Supplement (Part A) by signing and returning this Supplement (Part A) to your client manager or your authorized producer (broker) not later than 30 days prior to the effective date of this Renewal.

Standard Provisions Category

Post-payment Recovery Services	**Percentage Fee Based on Recovery**
Post-payment recovery services include, but are not limited to: Fraud, Waste and Abuse Reviews (provider and member); Facility Audits; Coordination of Benefits with other insurers	35%
Subrogation	35%
Claims Services	**Percentage Fee**
Pre-payment claims services include, but are not limited to: Fraud, Waste and Abuse Reviews (provider and member); Claim Coding Validation/Accuracy; Claim Coding Integrity (medical record review) and Pre-Claim Audit Services	35%
	Percentage Fee Based on the Difference Between Billed Charges and Priced Amount
Claim Pricing (Non-Contracted Provider Claims Negotiation Services)	40%
Claim Pricing (Non-Contracted Provider Claims Database Pricing)	40%
Claim Pricing (Par-Wrap Services)	40%
Claim Pricing (Non-Contracted Provider Claims) Fee Cap	$50K Cap
	Additional Fees
Percent of Administrative Fee for Post-Termination Services (fee in effect immediately prior to termination)	100%
External Review (Independent Review Organization)	$1000 per appeal

Claims Reprocessing	$25 per claim

Unless otherwise stated in a proposal document signed by Group (Proposal), Group further agrees that the fees set forth in this Supplement (Part A) shall, likewise, apply to agreed-upon programs and services set forth in the Proposal for the period set forth therein.

Group understands and agrees that the Renewal offer, and Group's acceptance of the Renewal, requires that a Group Representative sign each of the Renewal Acceptance Agreement, Supplement (Part A) and Supplement (Part B) (if applicable). Signing some, but not all of the components of the Renewal, does not constitute Group acceptance. Alternatively, Group agrees that the initial payment of administrative fees and/or claims cost for the Renewal Period described in the Renewal shall be deemed Group's complete acceptance of all of the terms and conditions of all components of the Renewal.

Accepted by: KJ Ashl Title: MAYOR

(Signature of Group Representative)

Email Address: ecklund@jamestownny.gov Date: 12/05/25

SUPPLEMENT (PART B) TO RENEWAL ACCEPTANCE AGREEMENT

Client Name: City of Jamestown
Client Number: 287748
Renewal Period: 01/01/2026 to 12/31/2026

This Supplement (Part B) to the Renewal Acceptance Agreement includes additional agreed upon terms concerning services and fees that will apply to our administrative services only agreement or claims billed cost-plus insurance contract (Service Agreement) during the Renewal Period.

The above named client (Group) understands and agrees that the Renewal Acceptance Agreement, Supplement (Part A) and Supplement (Part B) (collectively, the Renewal) supercedes and amends all of our Service Agreements. Accordingly the terms of this Supplement control over any conflicting terms in our Service Agreement.

Please have an authorized representative (Group Representative) accept the terms and conditions of this Supplement (Part B) by signing and returning this Supplement (Part B) to your client manager or your authorized producer (broker) not later than 30 days prior to the effective date of this Renewal.

Additional Products and Services Provided Summary by Product:

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Vision NY	Vision NY (WNY)	$6.00				Per Claim	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
MSK UM	MSK UM - Opt In	$110.00				Per Auth	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Well360	Virtual Physical Care Program					Per Claims Billed	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Mental Well-being	Mental Well-being - Opt Out	$0.00				Per Claims Billed	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Utilization Management (UM)	Utilization Management In Pat	$150.00				Per auth	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Radiology Cardiac Imaging UM	Radiology Cardiac Image UM - Opt In	$20.00				Per auth	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Utilization Management (UM)	Utilization Management Out Pat	$70.00				Per auth	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Well360 Model	Well360 Choice (Discount)	$0.00				PCPM	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Site of Care Oncology	Site of Care Oncology - Opt In	$1,750.00				Per infusion; billed quarterly	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Rx Program	RationalMed	$0.50				PCPM	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Claims Fiduciary	Claims Fiduciary	$1.50				PCPM	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Product / Services		Sold Price ($)	Pay Loc	Cap	Percent (%)	Frequency	Effective Begin Date	Effective End Date
Rx Program	Free Market Health Specialty	$1.25				Per Script	01/01/2026	12/31/2026
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38								

Credits Summary by Credit:

Type of Credit	Amount ($)	Credit to be Applied	Begin Date	End Date	Carryover
Loyalty Credit	$85,000.00	One-Time	01/01/2026	12/31/2026	No
Applies to Groups: 106617,-36,-43,-50; 107564,-35,-36,-37,-38,-39,-41,-42,-43,-44,-45,-46,-47,-48,-49,-50,-51,-52; 107723,-38					

Unless otherwise stated in a proposal document signed by Group (Proposal), Group further agrees that the fees set forth in this Supplement (Part B) shall, likewise, apply to agreed upon programs and services set forth in the Proposal for the period set forth therein.

Group understands and agrees that the Renewal offer, and Group's acceptance of the Renewal, requires that a Group Representative sign each of the Renewal Acceptance Agreement, Supplement (Part A) and Supplement (Part B). Signing some, but not all of the components of the Renewal, does not constitute Group acceptance. Alternatively, that notwithstanding anything in this Renewal Acceptance Agreement, Supplement (Part A) or Supplement (Part B) to the contrary, Group agrees that the initial payment of administrative fees and/or claims cost for the Renewal Period described in the Renewal shall be deemed Group's complete acceptance of all of the terms and conditions of all components of the Renewal.

Accepted by: [signature] Title: MAYOR

(Signature of Group Representative)

Email Address: ecklund@jamestownny.gov Date: 12/05/25

CITY OF
JAMESTOWN
NEW YORK

Agenda Date: _____

Agenda Item: _____

STAFF REPORT

Approved and Forwarded to City Council

Kimberly A. Ecklund, Mayor

DATE: February 17, 2026

TO: Kimberly A. Ecklund, Mayor

FROM: Ericka Thomas, Comptroller

SUBJECT: Stop Loss Contract - Symetra

ACTION: [X] **Resolution** [ ] **Ordinance/Local Law** [ ] **Informational/Report**

ISSUE STATEMENT: First Symetra National Life Insurance Company of New York Annual Stop Loss Insurance Agreement Renewal Effective January 1, 2026 to December 31, 2026.

BACKGROUND:

Symetra provided the only viable offer with coverage for all members at $200,000 individual deductibles.

Effective 1/1/26, health plan budget rates would include known stop loss costs for the entire plan year and therefore employee costs would reflect the actual known cost of stop loss for the full plan year.

FISCAL IMPACT: The cost of the Stop Loss is $218.93 per enrolled employee per month.

RECOMMENDATION:

Symetra as the Stop Loss provider for the contract year 1/1/2026-12/31/2026.

Increase individual specific deductible to $200,000 per member.

Approve the resolution to enter into an agreement with First Symetra National Life Insurance Company of New York

ATTACHMENT(S): 1. Resolution

BY COUNCIL:

RESOLVED, That the Mayor of the City of Jamestown be and she hereby is authorized to enter into an agreement with First Symetra National Life Insurance Company of New York, placed through USI Insurance Services, 7 West Third Street, Jamestown, New York 14701 for a specific excess stop-loss insurance policy for the period January 1, 2026 through December 31, 2026 in the amount of Two Hundred Thousand Dollars ($200,000.00) for specific deductible per participant, an annual unlimited maximum reimbursement, at a cost of Two Hundred Eighteen Dollars and Ninety-Three cents ($218.93) per enrolled employee per month, subject to the approval of the Corporation Counsel as to form.

CITY OF
JAMESTOWN
NEW YORK

Agenda Date: _____

Agenda Item: _____

STAFF REPORT

Approved and Forwarded to City Council

_____
Kimberly A. Ecklund, Mayor

DATE: February 19, 2026

TO: Kimberly A. Ecklund, Mayor

FROM: Legal Department

SUBJECT: Health Insurance Broker Services Agreement May 1, 2026 – May 1, 2029

ACTION: [X] **Resolution** [ ] **Ordinance/Local Law** [ ] **Informational/Report**

ISSUE STATEMENT: The City of Jamestown is a self insured entity providing health insurance to approximately 200 active employees and their families, as well as retirees. To navigate health insurance issues with the City's third party administrator, the City uses a health insurance broker. The City put brokerage service out to bid for May 1, 2026 – May 1, 2029. The City received five qualified bids in response to its request for proposals from licensed health insurance brokers in the State of New York.

.

Based upon cost and all things being equal with respect to services, the City has chosen Lawley Insurance Advisors to be its broker from May 1, 2026 – May 1, 2029.

BACKGROUND:

FISCAL IMPACT:

Cost per year:
2026: $60,000
2027: $61,800
2028: $63,654

There will be a $27,000 savings over three years, compared to all other bids received.

RECOMMENDATION: Adopt Resolution

ATTACHMENT(S): Resolution

February 23, 2026
Resolution #5

BY COUNCIL:

RESOLVED, That the Mayor or her authorized representative be, and hereby is authorized to enter into a health insurance broker agreement with Lawley insurance brokers for the next three years from May 1, 2026 – May 1, 2029 with the following costs per year: 2026- Sixty Thousand Dollars and No Cents ($60,000); 2027- Sixty-One Thousand, Eight Hundred Dollars and No Cents ($61,800); 2028- Sixty-Three Thousand, Six Hundred Fifty-Four Dollars and No Cents ($63,654), subject to the approval of the Corporation Counsel as to form.

CITY OF
JAMESTOWN
NEW YORK

Agenda Date: _____

Agenda Item: _____

STAFF REPORT

Approved and Forwarded to City Council

_____
Kimberly A. Ecklund, Mayor

DATE: February 19, 2026

TO: Kimberly A. Ecklund, Mayor

FROM: Legal Department

SUBJECT: PILOT Agreement- STEL

ACTION: [X] **Resolution** [ ] **Ordinance/Local Law** [ ] **Informational/Report**

ISSUE STATEMENT: Southern Tier Environmental Living STEL, is building a large affordable housing development at 31, 53, and 55 Water Street, in the City. Currently these properties are owned by a tax exempt entity and paying $0.00 to the City in tax. City legal in conjunction with STEL legal has negotiated a PILOT Agreement with STEL to provide $70,116.48 per year to the City for 15 years as a PILOT payment to the City.

.

BACKGROUND:

FISCAL IMPACT: $70,116.48 per year added to the City tax base for the next 15 years. Agreement to be revisited in the future.

RECOMMENDATION: Adopt Resolution and Agreement

ATTACHMENT(S): Resolution and Agreement

February 23, 2026
Resolution #6

BY COUNCIL:

RESOLVED, That the Mayor or her authorized representative be, and hereby is authorized to enter into a payment in lieu of tax agreement (PILOT) with Southern Tier Environments for Living, Inc. (STEL), 715 Central Avenue, Dunkirk, New York 14048 for a period not to exceed 15 years, for affordable new construction housing located at 31, 53 and 55 Water Street, Jamestown, NY 14701, in an annual amount of Seventy Thousand, One Hundred Sixteen Dollars and Forty-Eight Cents ($70,116.48) subject to the approval of the Corporation Counsel as to form.

PAYMENT IN LIEU OF TAXES AGREEMENT

THIS PAYMENT IN LIEU OF TAXES AGREEMENT ("PILOT Agreement") is made as of _____ day of _____, 20___ ("Effective Date") by and among the **CITY OF JAMESTOWN**, a municipal corporation organized and existing under the laws of the State of New York, having its principal office at 200 East Third Street, Jamestown, New York, 14701 (the "City"), **GATEWAY LOFTS HOUSING DEVELOPMENT FUND COMPANY, INC.**, a New York not-for-profit corporation organized pursuant to Article XI of the New York State Private Housing Finance Law (the "PHFL") with offices at 715 Central Avenue, Dunkirk, New York, 14048 (the "Taxpayer").

WITNESSETH:

WHEREAS, the Gateway Lofts Supportive Apartment, L.P. ("Gateway Lofts") and Southern Tier Environments for Living, Inc. ("STEL") in cooperation with Community Helping Hands ("CHH"), are proposing the redevelopment of the Gateway Center Lofts ("Project") located at 31 Water Street in Jamestown, New York. The Project will include the adaptive re-use of a portion of the existing Gateway Center located on approximately 5.58 acres, for multifamily affordable and supportive housing that will include 110 units, playground areas, walkways, picnic areas, greenspace, and other related site improvements; and

WHEREAS, the parcels located at 31, 53, and 55 Water Street are all contiguous and together they form the Project Site. Gateway Lofts will partner with Taxpayer and STEL to develop the Project, located on the Project Site, as more particularly described in **Schedule A**, attached hereto and made a part hereof, in the City of Jamestown (the "City"), County of Chautauqua and State of New York ("Land"); and

WHEREAS, the redevelopment of the Project on the Project Site is of vital public interest to the City; and

WHEREAS, the redevelopment of the Project is intended to create housing affordable to low income households, and affordability of the Project by low income persons shall remain consistent throughout the duration of the PILOT Agreement; and

WHEREAS, the City wishes to grant the Taxpayer such relief as permitted under Section 577 of the PHFL.

NOW, THEREFORE, in consideration of the covenants and agreements contained in this PILOT Agreement, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties covenant and agree as follows:

1. **Tax Exemption.** The parties agree that Taxpayer qualifies for a real property tax exemption for the Project in accordance with the provisions of Article 11 of the PHFL.

2. **Obligation of the Taxpayer to Make Payments in Lieu of Taxes.** The City requires, and the Taxpayer agrees to, make payments in lieu of real property taxes to the appropriate taxing authorities pursuant to the real estate tax policies of the City and the County of Chautauqua, subject to the terms of this PILOT Agreement.

3. **Requirements of Taxpayer.**

a. The redevelopment of the Project shall be carried out in accordance with the provisions of Article 11 of the PHFL and in compliance with the reasonable requirements of the Planning Board of the City of Jamestown.

b. The PILOT Agreement is to commence on the Commencement Date, as hereinafter defined, and be concurrent with the Project's use as affordable housing and for so long as a municipality aided, state aided and/or federally aided mortgage is outstanding on the Project, but shall not exceed fifteen (15) complete fiscal years following the Commencement Date.

c. The Taxpayer shall provide the City with such information concerning its operations and the operations of the Project in form and substance as may from time to time be reasonably requested. Such information shall include, but shall not be limited to, the annual financial statements of the Taxpayer from the calendar year immediately preceding the fiscal year in which payments are due.

d. The Taxpayer shall permit the Comptroller of the City to audit its books and records within fourteen (14) days after receiving a written request from the City at the Taxpayer's office.

e. Transfer of legal title to the Land and improvements comprising of the Project will not be allowed during the term of this PILOT Agreement without the prior written consent of the City, not to be unreasonably withheld.

f. The Taxpayer shall utilize general City services for the Project at rates comparable for similar properties.

4. **Taxing Authorities and Amounts.**

a. Upon commencement of the City's next fiscal year commencing after the taxable status date immediately following substantial completion of the Project described herein as evidenced by receipt of a Certificate of Occupancy (the "Commencement Date"), the Taxpayer shall make annual payments in lieu of local and municipal real estate taxes, including school taxes, other than assessments for local improvements, levied by or in behalf of such taxing jurisdictions, as follows:

i. The Taxpayer will make a fixed annual PILOT payment in the amounts as stated in **Schedule B,** attached hereto and made a part hereof, in satisfaction of all real property taxes;

ii. The PILOT payment shall be allocated and/or distributed by the City between the various entities currently assessing taxes against the Project, except the Taxpayer will be responsible for paying all assessments for local improvements, levied by or in behalf of such taxing jurisdictions permitted by law;

iii. At the expiration of the fifteen (15) year period, describe in Section 3(b), this PILOT Agreement will cease to have any effect on the taxes due with respect to the Project and the Project will be taxed in accordance with applicable law.

b. Each of the foregoing payments shall be made on or before the date that the particular tax payment would have been due to the City.

c. The Taxpayer shall prepare all documents and forms required under this PILOT Agreement. The City shall reasonably cooperate with regard to the preparation, execution, and filing of the same.

5. **Defaults in Payment in Lieu of Taxes.** In the event the Taxpayer fails to make any payment in lieu of real property taxes when due, the amount or amounts not so paid shall be a lien on the Project in the same manner that delinquent real property taxes would be and continue as an obligation to the Taxpayer until fully paid. In addition, the Taxpayer shall pay the appropriate taxing authorities' or authorities' interest and penalties on the unpaid amount or amounts accruing at the same times and at the interest rates as if such amounts were delinquent real property taxes. In addition to any other remedies available to it for the collection of delinquent real property taxes, including, without limitation, in rem proceedings, the City may exercise any other remedies available, and such remedies shall be cumulative, and the exercise of any remedy shall not be an election of remedies under law.

6. **Effect of Fulfillment of the Requirement.** Once having paid the amounts required by this PILOT Agreement when due, the Taxpayer shall not be required to pay any real property taxes for which such payments in lieu of taxes have been made, except assessments for local improvements, levied by or in behalf of both such taxing jurisdictions, permitted by law.

7. **Events of Default and Termination of Tax Exemption.**

a. A default ("Default") shall be defined as (1) failure of the Taxpayer to make any payment required under the PILOT Agreement when due; (2) the Taxpayer's failure to provide any notice as required by this PILOT Agreement to the City; (3) Taxpayer's failure to qualify, or continue to qualify, for a real property tax exemption for the Project in accordance with Article 11 of the PHFL; (4) failure of Taxpayer to provide any of the information required by Section 3(c) or 3(d) of this PILOT Agreement; or (5) the transfer of title or beneficial ownership of any portion of the Project or the Land, without the consent of the City, not to be unreasonably withheld.

b. Upon the occurrence of an Default as defined pursuant to Section 7(a) above, the Taxpayer shall have ten (10) days after the receipt of Notice from the City regarding such Default to cure such Default. Failure to timely cure such Default shall be deemed an event of default ("Event of Default") hereunder.

c. In the event the Taxpayer has not cured such default or defaults within the time period set forth in this PILOT Agreement, then the exemption from real property taxes described herein shall be deemed to have been terminated as of the taxable status date of the City's immediately succeeding fiscal year.

d. Upon termination of the exemption from real property taxes set forth in Section 7(c) above, the Taxpayer shall be liable for real property taxes on a pro-rata basis from and after the City's taxable status date immediately succeeding the Event of Default and the statutory lien applicable to such real property taxes shall be deemed in effect as of the lien date normally applicable to such year's real property taxes, unless a separate basis for a real property tax exemption then exists for the benefit of Taxpayer.

e. Any such termination of the real property tax exemption applicable to the Project shall not void the liability of the Taxpayer for any unpaid payments in lieu of taxes required by this PILOT Agreement prior to such termination.

8. **Notices.** All notices, certificates and other communications hereunder shall be in writing and shall be sufficiently given and shall be deemed given, if by delivery, when delivered and, if delivered by mail, on the second day following the day on which mailed by certified mail, postage prepaid, addressed as follows:

To the City:	City of Jamestown 200 East Third Street Jamestown, New York 14701 Attention: Mayor Kimberly Ecklund
With a copy to:	City of Jamestown, Corporation Counsel 200 East Third Street Jamestown, New York 14701 Attention: Elliot S. Raimondo, Esq.
To Taxpayer:	Gateway Lofts Housing Development Fund Company, Inc. 715 Central Avenue Dunkirk, New York, 14048 Attention: Steven Ald, Vice President
With a copy to:	Phillips Lytle, LLP One Canalside, 125 Main Street Buffalo, New York, 14203

Attention: Diana Konik, Esq.

The City or Taxpayer may, by notice given hereunder, designate any further or different addresses to which subsequent notices, certificates and other communications shall be sent.

9. **Assignment of PILOT Agreement.** This PILOT Agreement shall be binding upon the successors and assigns of Taxpayer, but no assignment shall be effective to relieve Taxpayer of any of its obligations hereunder unless expressly authorized and approved in writing by the City. The rights and obligations of Taxpayer hereunder may not be assigned except in connection with a permitted assignment of Taxpayer's interest in and to the Project. Nothing herein is intended to be for, or to inure to, the benefit of any Person other than the parties hereto.

10. **Waiver.** No failure on the part of the City to exercise, and no delay on the part of the City in exercising, any right, power or remedy hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of such right, power or remedy by the City preclude any other or further exercise thereof or the exercise of any other right, power or remedy.

11. **Amendments.** Neither this PILOT Agreement nor any provision hereof may be amended, modified, waived, discharged or terminated, except by an instrument in writing duly executed and agreed to by the parties hereto.

12. **Severability.** In the event any provision of this PILOT Agreement shall be held invalid or unenforceable by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision hereof.

13. **Prior Agreements; Counterparts.** This PILOT Agreement constitutes the entire agreement, and supersedes all prior agreements and understandings, whether written or oral, among the parties with respect to the subject matter hereof and may be executed simultaneously in several counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

14. **Applicable Law.** This PILOT Agreement shall be governed and construed under the internal laws of the State of New York, as the same may be in effect from time to time, without regard to principles of conflicts of law.

15. **Waiver of Jury Trial.** The City and Taxpayer hereby waive the right each may have to a trial by jury in respect of any litigation arising in connection with this PILOT Agreement.

[Remainder of This Page Intentionally Left Blank]

IN WITNESS WHEREOF, the City, Taxpayer, and have executed this PILOT Agreement as of the date first above written.

CITY OF JAMESTOWN

By: _____
_____
_____

STATE OF NEW YORK)
) SS.:
COUNTY OF CHAUTAUQUA)

On the ___ day of _____, 20__, before me, the undersigned, a Notary Public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to by the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed this instrument.

_____
Notary Public

[PILOT Agreement Execution Page]

GATEWAY LOFTS HOUSING DEVELOPMENT FUND COMPANY, INC.
By:_____
Name: Steven Ald
Title: Vice President

STATE OF NEW YORK)
) SS.:
COUNTY OF CHAUTAUQUA)

On the ___ day of _____, 20__, before me, the undersigned, a Notary Public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to by the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed this instrument.

_____
Notary Public

[PILOT Agreement Execution Page]

Schedule A

Legal Description (to be included upon filing with the County Clerk)

Schedule B

PILOT Year	Annual PILOT Payment
1	$70,116.48
2	$70,116.48
3	$70,116.48
4	$70,116.48
5	$70,116.48
6	$70,116.48
7	$70,116.48
8	$70,116.48
9	$70,116.48
10	$70,116.48
11	$70,116.48
12	$70,116.48
13	$70,116.48
14	$70,116.48
15	$70,116.48