EMPLOYEE HEALTH INSURANCE CY 22 TO CY 23 COST COMPARISON

MEDICAL

Calendar Year 2022 Premiums

Employee	Premium	Employee Contribution (80%)	Employer Contribution (20%)
Benner	$ 383.31	$ 306.65	$ 76.66
Shlagman	$ 1,027.65	$ 822.12	$ 205.53
Wiak	$ 415.86	$ 332.69	$ 83.17
Total Monthly	**$ 1,826.82**	**$ 1,461.46**	**$ 365.36**
Annual	**$ 21,921.84**	**$ 17,537.47**	**$ 4,384.37**

Calendar Year 2023 Premiums

Employee	Premium	Employee Contribution (80%)	Employer Contribution (20%)
Benner	$ 394.34	$ 315.47	$ 78.87
Shlagman	$ 1,042.32	$ 833.86	$ 208.46
Wiak	$ 421.79	$ 337.43	$ 84.36
Total Monthly	**$ 1,858.45**	**$ 1,486.76**	**$ 371.69**
Annual	**$ 22,301.40**	**$ 17,841.12**	**$ 4,460.28**
		(+/-)	**$ 75.91**

Note: Calendar year to year increase is 1.017%

Account Name: VILLAGE OF LONG GROVE
Account Number: 548881
Agent: J KRUG AND ASSOCIATES INC
Renewal Effective Date: Jan 1, 2023
Rating Area: 2

Renewal at a Glance

Current and Renewal Medical Plans and Premiums

Your group's current Medical plan(s) and suggested plans for the upcoming year are listed below.

If these plans aren't a good fit for the new year, don't worry, you've got more plans to choose from in the *Medical Plans* section.

	Current Plan	Renewal Plan
Plan ID	S507OPT	S507OPT
Metallic	Silver	Silver
Network Name	Blue Options Tiered Product - Blue Options PPO	Blue Options Tiered Product - Blue Options PPO
Deductible In-Network // Out-of-Network	$4000 BC / $4750 PPO//$9500	$4600 BC / $5300 PPO//$10600
Primary Care/Telehealth Visit	DC/DC	DC/DC
Coinsurance In-Network // Out-of-Network	100% BC / 80% PPO//50%	100% BC / 70% PPO//50%
Out-of-Pocket Max In-Network // Out-of-Network	$4000 BC / $8900 PPO//Unlimited	$4600 BC / $7050 PPO//Unlimited
Specialist Office Visit	DC	DC
Non Preferred Pharmacy Copays	100%	100%

More information on rates is available in the *Appendix – Monthly Medical Premiums* section. To view other plans, see the *Medical Plans* section.

DENTAL

Calendar Year 2022 Premiums

Employee	Premium	Employee Contribution (100%)	Employer Contribution (0%)
Benner	$ 56.04	$ 56.04	$ -
Shlagman	$ 56.04	$ 56.04	$ -
Wiak	$ 56.04	$ 56.04	$ -
Total Monthly	**$ 168.12**	**$ 168.12**	**$ -**
Annual	**$ 2,017.44**	**$ 2,017.44**	**$ -**

Calendar Year 2023 Premiums

Employee	Premium	Employee Contribution (80%)	Employer Contribution (20%)
Benner	$ 57.72	$ 46.18	$ 11.54
Shlagman	$ 57.72	$ 46.18	$ 11.54
Wiak	$ 57.72	$ 46.18	$ 11.54
Total Monthly	**$ 173.16**	**$ 138.53**	**$ 34.63**
Annual	**$ 2,077.92**	**$ 1,662.34**	**$ 415.58**
		(+/-)	**$ 415.58**

VISION

Calendar Year 2022 Premiums

Employee	Premium	Employee Contribution	Employer Contribution
Benner	$ -	$ -	$ -
Shlagman	$ -	$ -	$ -
Wiak	$ -	$ -	$ -
Total Monthly	**$ -**	**$ -**	**$ -**
Annual	**$ -**	**$ -**	**$ -**

Calendar Year 2023 Premiums

Employee	Premium	Employee Contribution (80%)	Employer Contribution (20%)
Benner	$ 6.84	$ 5.47	$ 1.37
Shlagman	$ 6.84	$ 5.47	$ 1.37
Wiak	$ 6.84	$ 5.47	$ 1.37
Total Monthly	**$ 20.52**	**$ 16.42**	**$ 4.10**
Annual	**$ 246.24**	**$ 196.99**	**$ 49.25**
		(+/-)	**$ 49.25**

HRA

Calendar Year 2022 Premiums

Employee	Employee 1st Out of Pocket	Employer Contribution Max
Benner	$ 1,400.00	$ 4,500.00
Shlagman	$ 1,400.00	$ 4,500.00
Wiak	$ 1,400.00	$ 4,500.00
Annual		**$ 13,500.00**

Calendar Year 2023 Premiums

Employee	Employee 1st Out of Pocket	Employer Contribution
Benner	$ 1,500.00	$ 4,500.00
Shlagman	$ 1,500.00	$ 4,500.00
Wiak	$ 1,500.00	$ 4,500.00
Annual		**$ 13,500.00**

Total CY 2023 increase to the Village will be $540.74 for an annual employer contribution of $4925.11. This increase includes the added benefit of Delta Vision Coverage. There is no increase in the HRA Employer contribution, but there is a $100 increase in the employee 1st out of pocket expense. Deductible for employee increases by $700.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsil.com/member/policy-forms/2023 or by calling 1-800-541-2768. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Blue Choice $4,600; PPO $5,300; Out-of-Network $10,600 Family: Blue Choice $13,800; PPO $14,100; Out-of-Network $28,200	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Individual: Blue Choice $4,600; PPO $7,050; Out-of-Network Unlimited Family: Blue Choice $13,800; PPO $14,100; Out-of-Network Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-541-2768 for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	PPO Provider (You will pay more)	Non-PPO Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge after deductible	30% coinsurance	50% coinsurance	Virtual Visits: No Charge after deductible. See your benefit booklet* for details.
	Specialist visit	No Charge after deductible	30% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/member/policy-forms/2023.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	PPO Provider (You will pay more)	Non-PPO Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsil.com/rx23/6T	Preferred generic drugs	No Charge after deductible.	No Charge after deductible	Retail - No Charge after deductible	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Any differences between the cost of the generic drug and the cost of the brand name drug will apply to the deductible or out-of-pocket maximum. The applicable cost sharing (by tier) and the cost difference between the generic and brand will never exceed the overall cost of the drug. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copayment/coinsurance. Additional charge will not apply to any deductible or out-of-pocket amounts. The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed $100, when obtained from a Preferred Participating or Participating Pharmacy.
	Non-preferred generic drugs	No Charge after deductible	No Charge after deductible	Retail - No Charge after deductible	
	Preferred brand drugs	No Charge after deductible	No Charge after deductible	Retail - No Charge after deductible	
	Non-preferred brand drugs	No Charge after deductible	No Charge after deductible	Retail - No Charge after deductible	
	Preferred specialty drugs	No Charge after deductible	No Charge after deductible	No Charge after deductible	
	Non-preferred specialty drugs	No Charge after deductible	No Charge after deductible	No Charge after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	No Charge after deductible	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	No Charge after deductible	No Charge after deductible	No Charge after deductible	None
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	No Charge after deductible	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	No Charge after deductible	30% coinsurance	50% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/member/policy-forms/2023.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	PPO Provider (You will pay more)	Non-PPO Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization required. Preauthorization penalty: $1,000 or 50% of the eligible charge In-Network, $500 Out-of-Network. See your benefit booklet* for details.
	Physician/surgeon fees	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization required.

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/member/policy-forms/2023.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Blue Choice Provider (You will pay the least)	PPO Provider (You will pay more)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization required.
If you are pregnant	Office visits	No Charge after deductible	30% coinsurance	50% coinsurance	Cost sharing does not apply for certain preventive services. Depending on the type of services, deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge after deductible	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	No Charge after deductible	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Rehabilitation services	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Habilitation services	No Charge after deductible	30% coinsurance	50% coinsurance	
	Skilled nursing care	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Durable medical equipment	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Hospice services	No Charge after deductible	30% coinsurance	50% coinsurance	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	No Charge; deductible does not apply	Up to a $30 reimbursement is available; deductible does not apply	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's glasses	No Charge after deductible	No Charge after deductible	Up to a $75 reimbursement is available; deductible does not apply	One pair of glasses per year up to age 19. Reimbursement for frames, lenses and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's dental check-up	30% coinsurance	30% coinsurance	50% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/member/policy-forms/2023.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Dental care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care (Chiropractic and Osteopathic manipulation limited to 25 visits per calendar year) • Cosmetic surgery (only for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)	• Hearing aids (for children 1 per ear every 24 months, for adults up to $2,500 per ear every 24 months) • Infertility treatment (covered for 4 procedures per benefit period)	• Private-duty nursing (with the exception of inpatient private-duty nursing) • Routine foot care (when medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-541-2768, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1-877-527-9431 or visit http://insurance.illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/member/policy-forms/2023.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-541-2768.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-541-2768.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-541-2768.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, see the plan or policy document at http://www.bcbsil.com/member/policy-forms/2023.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$4,600
Specialist	$0
Hospital (facility)	$0
Other	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,660

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,600
Specialist	$0
Hospital (facility)	$0
Other	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,600
Specialist	$0
Hospital (facility)	$0
Other	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यिद आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा म निःशुल्क सहायता और जानकारी प्राप्त करन का अधिकार है। किसी अनवादक स बात करन क लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'idiłkidgo, ts'idá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'idiłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

DELTA DENTAL

October 19, 2022

T1 P1***AUTO**ALL FOR AADC 601 S-10
J KRUG & ASSOCIATES INC
1 PIERCE PL STE 1250W
ITASCA, IL 60143-1253

Renewal for Village Of Long Grove Il, Group #36661

Thank you for choosing Delta Dental of Illinois as your dental benefits carrier. Oral health is key to overall health, and preventive care is vital to good oral health. We're delighted to provide your group with dental coverage to help your employees get the oral health care they need, and especially pleased to partner with your group to help ensure your employees and their covered dependents have a lifetime of healthy smiles.

We are pleased to present Delta Dental of Illinois' renewal package for Village Of Long Grove Il, Group #36661. Renewal rates for your selected plan/s and coverage/s are below.

Renewal and Current Rates – Delta Dental of Illinois
Rates are effective: January 1, 2023- December 31, 2024

Delta Dental PPO	**Current Rates**	**Renewal Rates**
Single	**$56.04**	**$57.72**
Family	**$151.27**	**$155.45**

**The rates include Delta Dental of Illinois' expected tax imposed by the Affordable Care Act (ACA), which is 1.2%. This percentage will be evaluated during the year and may be adjusted if necessary.*

One Good Plan Deserves Another
Groups can receive a discount of 2% on their dental plan rate by adding a qualifying DeltaVision®* group product to a Delta Dental of Illinois dental plan. DeltaVision is offered in association with EyeMed Vision Care networks. Our vision plans offer quality coverage, single-site administration, larger networks, more benefits and a better member experience. We have included two DeltaVision quotes for your review.

Smart Option Non-Benefit Eligible Employees
Delta Dental of Illinois strives to help all of your employees as healthy as possible. Individuals with dental insurance go to the dentist more than those without to get the oral health care services they need. Consider our dental plans for Illinois individuals and families for your non-benefit eligible employees. Please visit deltadentalil.com and select Shop for Plans for more details on our individual product offerings.

ACA/EHB rider option
Groups with 50 or fewer employees can choose to add the Delta Dental of Illinois Individual Kids Preferred Plan as an ACA rider to their plan. The Individual Kids Preferred Plan uses the Delta Dental PPO network with an Exclusive Provider Feature where benefits are paid only when a member uses a Delta Dental PPO dentist. Delta Dental PPO dentists cannot bill members for charges over the PPO allowed amount. Please contact us if you'd like a quote.

Wellness: Plan Enhancements
All of our Delta Dental PPO and Delta Dental Premier plans include coverage for implant therapy and posterior composites (tooth-colored fillings on back teeth) and our Enhanced Benefits Program. This program enhances coverage for individuals who have specific health conditions that can be positively affected by additional oral health care. Conditions include diabetes, pregnancy, periodontal disease, high-risk cardiac conditions, kidney disease, cancer-related chemotherapy and radiation, and suppressed immune systems.

You can also visit deltadentalil.com/oralhealth for a host of oral health resources.

We value your business. We have enjoyed our business partnership and look forward to continuing our relationship. If you have any questions, please contact me. **If we do not receive a signed letter from you by December 15th, Delta Dental of Illinois will assume you agree to the proposed rates for your existing benefit plans and renew your existing benefit plans.**

Sincerely,
Delta Dental of Illinois Small Group Team
630-718-4767
smallgroupteam@deltadentalil.com

DELTA DENTAL

Proposed Renewal Acceptance Page for Existing Plan Design

1. The proposed renewal rates will be in effect for the following time period: January 1, 2023 – December 31, 2024.

2. All of our standard processing policies, limitations and exclusions apply.

3. Please acknowledge your acceptance of these terms and rates by signing below and returning this page. You can fax or email a copy of this letter to Delta Dental of Illinois Small Group Team at 630-983-4523 or smallgroupteam@deltadentalil.com.

If we do not receive a signed letter from you by December 15th, Delta Dental of Illinois will assume you agree to the proposed rates and renew your existing benefit plan.

AGREED AND ACCEPTED:

Village Of Long Grove Il, Group #36661

By: _____ Date: _____

Title: _____

DeltaVision®
Edge Insight Vision Program

DELTA DENTAL

Vision Care Services	Insight Network In-Network Member Cost	Out-of-Network
Exam with Dilation as Necessary:	$10 Copay	$35
Contact Lens Fit & Follow-up: (Available once a comprehensive eye exam has been completed)		
Standard*	Member pays up to $40 for fit and two follow-up visits	N/A
Premium**	10% off retail price	N/A
Frames: (Any available frame at provider location)	$130 allowance, 20% off balance over allowance	$65
Standard Plastic Lenses:		
Single Vision	$25 Copay	$25
Bifocal	$25 Copay	$40
Trifocal	$25 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Progressive (in addition to Bifocal copay)	$65	$40
Premium Progressive (in addition to Bifocal copay)	Tier 1 - $110, Tier 2 - $120, Tier 3 - $135, Tier 4 - $90, 80% of retail, less $120 allowance	$40
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating	Tier 1 - $57, Tier 2 - $68, Tier 3 - 80% of charge	N/A
Photocromatic/Transition Plastic	$75	N/A
Polarized	80% of charge	N/A
Other Add-Ons and Services	20% discount off retail price	N/A
Contact Lenses: (Contact Lens allowance covers materials only)		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay, $130 allowance, plus balance over $130	$104
Visually Required	$0 Copay, Paid-in-Full	$200
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include, but are not limited to, disposable and frequent replacement)
**Premium Contact Lens Fitting -all lens designs, materials and specialty fittings, other than Standard Contact Lenses(Examples include toric and multifocal)

Additional Discounts

Member will receive a 20% discount at network providers on items not covered by the plan. This discount may not be combined with any other discounts or promotional offers and the discount does not apply to contact lenses or a network provider's professional services. Retail prices may vary by location. Discount will not apply if manufacturer imposes a no-discount policy.

Member will also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. Discount will not apply if manufacturer imposes a no-discount policy.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. The contact lens benefit allowance is not applicable to this service.

LASIK or PRK: DeltaVision members can receive a discount of 15% off retail price or 5% off promotional price from contracted providers. Please contact DeltaVision for a current list of LASIK/PRK providers.

All of our standard processing policies and provisions, limitations and exclusions apply. Rates are based on the employer contributing at least 50% of the vision benefit premium or the employer offering the Delta Dental benefit plan and the DeltaVision plan bundled together. When the Delta Dental benefit plan and the DeltaVision plan are bundled, enrollees must elect both dental and vision coverage and are required to have the same enrollment tier for both plans.

Effective Date:	**01/01/2023**	Employee	$ 4.85
Rate Guarantee:	**Two Year**	Employee + Spouse	$ 9.47
This quote includes 10.00% Commissions.		Employee + Child(ren)	$ 10.59
Plan ID: 1006649 424		Family	$ 15.30

If you have selected this vision benefit proposal, please sign below and attach to group application.

Administrator: _____ Date: _____

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EveMed Vision Care networks.

DeltaVision®
Edge Insight Vision Program

DELTA DENTAL®

Vision Care Services	Insight Network In-Network Member Cost	Out-of-Network
Exam with Dilation as Necessary:	$10 Copay	$35
Contact Lens Fit & Follow-up: (Available once a comprehensive eye exam has been completed)		
Standard*	Member pays up to $40 for fit and two follow-up visits	N/A
Premium**	10% off retail price	N/A
Frames: (Any available frame at provider location)	$130 allowance, 20% off balance over allowance	$65
Standard Plastic Lenses:		
Single Vision	$25 Copay	$25
Bifocal	$25 Copay	$40
Trifocal	$25 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Progressive (in addition to Bifocal copay)	$65	$40
Premium Progressive (in addition to Bifocal copay)	Tier 1 - $110, Tier 2 - $120, Tier 3 - $135, Tier 4 - $90, 80% of retail, less $120 allowance	$40
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating	Tier 1 - $57, Tier 2 - $68, Tier 3 - 80% of charge	N/A
Photocromatic/Transition Plastic	$75	N/A
Polarized	80% of charge	N/A
Other Add-Ons and Services	20% discount off retail price	N/A
Contact Lenses: (Contact Lens allowance covers materials only)		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay, $130 allowance, plus balance over $130	$104
Visually Required	$0 Copay, Paid-in-Full	$200
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include, but are not limited to, disposable and frequent replacement)
**Premium Contact Lens Fitting -all lens designs, materials and specialty fittings, other than Standard Contact Lenses(Examples include toric and multifocal)

Additional Discounts

Member will receive a 20% discount at network providers on items not covered by the plan. This discount may not be combined with any other discounts or promotional offers and the discount does not apply to contact lenses or a network provider's professional services. Retail prices may vary by location. Discount will not apply if manufacturer imposes a no-discount policy.

Member will also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. Discount will not apply if manufacturer imposes a no-discount policy.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. The contact lens benefit allowance is not applicable to this service.

LASIK or PRK: DeltaVision members can receive a discount of 15% off retail price or 5% off promotional price from contracted providers. Please contact DeltaVision for a current list of LASIK/PRK providers.

All of our standard processing policies and provisions, limitations and exclusions apply. Rates are based on the employer contributing less than 50% of the vision benefit premium.

Effective Date:	**01/01/2023**	Employee	$ 6.84
Rate Guarantee:	**Two Year**	Employee + Spouse	$ 13.34
This quote includes 10.00% Commissions.		Employee + Child(ren)	$ 14.92
Plan ID: 1006649 524		Family	$ 21.56

If you have selected this vision benefit proposal, please sign below and attach to group application.

Administrator: _____ Date: _____

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

ACTIONS TAKEN AND RESOLUTIONS ADOPTED BY CONSENT OF
Village of Long Grove

The undersigned, of **Village of Long Grove** (the "Employer"), hereby adopt the following resolutions and direct that this Consent Resolution be entered in the minute books of the Employer.

WHEREAS the Employer desires to amend the ***Village of Long Grove Flex HRA*** definition of ***Flex HRA Plan Adoption Agreement Item 9: HRA Parameters 9.01 and 9.02 Benefit Descriptions***, effective ***January 1, 2023***, as set forth in the attached Amendment; and

NOW, THEREFORE, BE IT RESOLVED, that the Employer hereby adopts the attached amendment effective as of ***January 1, 2023.***

BE IT FURTHER RESOLVED that the Representatives of the Employer are authorized and directed to take all action as may be necessary to effectuate this Resolution.

By _____ Date_____

By_____ Date_____

By_____ Date_____

AMENDMENT TO THE

VILLAGE OF LONG GROVE

Health Reimbursement Arrangement

This Amendment to the **Village of Long Grove** HRA Plan is adopted by **VILLAGE OF LONG GROVE** (the "Employer"), effective as of the date set forth herein.

WHEREAS the Employer desires to amend Plan's definition of ***Flex HRA Plan Adoption Agreement Item 9: HRA Parameters 9.01 and 9.02 Benefit Descriptions.***

NOW, THEREFORE, effective ***January 1, 2023***, the definition ***Flex HRA Plan Adoption Agreement Item 9: HRA Parameters 9.01 and 9.02 Benefit Descriptions*** in the Plan is replaced with the following definition:

9.01 HRA – EE

Tiers	**Annual Contributions**
Employee	**$4,500.00**
Reimbursement Parameter	
Claims	**Reimbursement**
$0.00 - $1,500.00	**0%**
$1,501.00 - $6,000.00	**100%**
$6,001.00 - $7,050.00	**0%**

9.02 HRA – EF

Tiers	**Annual Contributions**
Employee Family	**$6,900.00**
Reimbursement Parameter	
Claims	**Reimbursement**
$0.00 - $3,000.00	**0%**
$3,001.00 - $9,900.00	**100%**
$9,901.00 - $14,100.00	**0%**

IN WITNESS WHEREOF, and as evidence of the adoption of the amendments set forth herein, the undersigned representative of **Village of Long Grove** has executed this Amendment to the Plan, this ____ day of _____, 2022.

Village of Long Grove

By: _____

Title: _____

Summary of Material Modification to Village of Long Grove Flex HRA

To: **Employee and COBRA Participants in the Village of Long Grove Flex HRA**
From: **Greg Jackson, Village Manager**
Date: **November 16, 2022**

The Village of Long GroveFlex HRA sponsored by Village of Long Grove has been revised. All the changes summarized below are effective ***January 1, 2023***.

9.01 HRA – EE

Tiers	**Annual Contributions**
Employee	**$4,500.00**
Reimbursement Parameter	
Claims	**Reimbursement**
$0.00 - $1,500.00	**0%**
$1,501.00 - $6,000.00	**100%**
$6,001.00 - $7,050.00	**0%**

9.02 HRA – EF

Tiers	**Annual Contributions**
Employee Family	**$6,900.00**
Reimbursement Parameter	
Claims	**Reimbursement**
$0.00 - $3,000.00	**0%**
$3,001.00 - $9,900.00	**100%**
$9,901.00 - $14,100.00	**0%**

Please attach this Summary of Material Modification to your Summary Plan Description for future reference.

Please contact me, Greg Jackson, Village Manager (acting on behalf of the plan administrator, Village of Long Grove), if you have questions regarding the information in this Summary of Material Modification, or if you need another copy of the Summary Plan Description.

I can be reached at (224) 352-2577. Or you can write me at:

Village of Long Grove
3110 Old McHenry Road
Long Grove, IL 60047
Attn: Greg Jackson, Village Manager

ERISA Information:

Plan Sponsor:	Village of Long Grove
Sponsor's EIN:	36-2704810
Plan Name:	Village of Long Grove Flex HRA
Plan Number:	504
Plan Year:	01/01/2023