The Village

Where real change happens

2024-2025
Employee Benefit Overview

Presented by:

NFP

An Aon Company

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The Village for Families & Children

Our Mission

To build a community of strong, healthy families who protect and nurture children.

Our Team

Dedicated, experienced staff members providing a circle of effective services around children and families.

Our Benefits

Our mission to provide quality services and programs to our clients depends on you, every day. We realize that our staff is our most important asset and because of that, we strive to make our agency a great place to work.

The following pages describe some of the benefits we provide to help keep you and your family healthy and protected.

The Village is committed to offering competitive insurance benefits that provide meaningful protection to you and your family.

Please take the time to thoroughly review your employee benefit plan, as it is an important part of your overall compensation package. The HR department is available to assist you with any questions you may have.

Your Benefit Options

Below is a listing of the insurance benefits offered bythe Village.

Medical & Pharmacy Coverage
Our medical provider is CIGNA. We offer an HSA-qualified High Deductible Health Plan (HDHP).
Health Savings Accounts
Our HSA banking partner is HSA Bank. You may be eligible to open a Health Savings Account if you enroll in our High Deductible Health Plan. Some restrictions apply; please see Human Resources if you havequestions.
Flexible Savings Accounts
Our FSA vendor is Inspira Financial (formerly PayFlex). We offer a Medical Care and a Dependent Care FSA.
Dental Coverage
Through CIGNA, our dental provider, we offer the Total CIGNA DPPO dental plan.
Vision Coverage
A voluntary vision plan is offered through Anthem.
Employee Basic Life, Accidental Death (AD&D) and Dependent LifeInsurance
Insured by CIGNA Life, The Village provides basic life insurance coverage on employees, spouses and eligible dependents at no cost to the employee. Supplemental coverage is available for purchase.
Short Term & Long Term Disability
Short term disability income replacement benefits are offered on a voluntary basis. Long term disability income replacement benefits are provided at no cost to the employee. Both plans are insured by CIGNA.

Eligibility & Enrollment

Employees who work at least 20 hours per week are eligible to participate in The Village benefit plans. Newly-hired employees can join on the first of the month following 30 days of employment; and those experiencing qualifying events (see HR for details).

Eligible Dependents

Many of the benefit plans also offer coverage for your eligible dependents. Eligible dependents include:

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Any children for whom you are responsible under court order;

Dependent age restrictions apply. Plan requirements are as follows:

	Dependent Age Rule	When Coverage Ends
Medical Insurance	**To age 26 without regard to employment, student or marital status**	**Coverage ends on the last day of the month in which you, and your covered dependents, are no longer eligible.** **Dependent children can remain on the plan through the end of the Plan Year (6/30) in which they turn age 26.**
Dental Insurance	**To age 26 without regard to employment, student or marital status**	**Coverage ends on the last day of the month in which you, and your covered dependents, are no longer eligible.** **Dependent children can remain on the plan through the end of the plan year (6/30) in which they turn age 26.**
Vision Insurance	**To age 26 without regard to employment, student or marital status**	**Coverage ends on the last day of the month in which you, and your covered dependents, are no longer eligible.** **Dependent children can remain on the plan through the end of the plan year (6/30) in which they turn age 26.**
Life Insurance	**To age 26**	**Coverage ends on the last day of the month in which you, and your covered dependents, are no longer eligible.** **Dependent children can remain on the plan up until the birthday that the dependent ceases to be an eligible dependent.**

Medical Insurance — CIGNA

Our medical plan, the CGNA High Deductible Health Plan (HDHP), covers a wide range of medical services to treat a non-work related illness or injury. The plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. The plan provides benefits you would receive from a typical health plan, plus the ability to contribute to a tax-advantaged health savings account (HSA). Below is a summary of the medical plan benefits. **High Deductible Health Plan (HDHP)**

	In-Network	Out-of-Network
Deductible	$2,500 Individual / $5,000 Family	$5,000 Individual / $10,000 Family
Co-insurance	N/A	30%
Out-of-Pocket Maximum	$3,500 Individual / $7,000 Family	$7,000 Individual / $14,000 Family
Preventive Care	Covered at 100%, deductible waived	30% after deductible
Office Visit / Specialist Visit	$0 after deductible	30% after deductible
Emergency Room	$0 after deductible	Same as in-network 30%
Outpatient / Inpatient	$0 after deductible	after deductible
Lifetime Maximum	Unlimited	Unlimited
	In-Network Prescription Benefits*	
	Retail (30 Days)	**Mail Order (31-90 Days)**
Tier 1 / Tier 2 / Tier 3	$5 / $35/ $50 after deductible	$10 / $70 / $100 after deductible

*To look-up a specific medication, visit *www.mycigna.com* where you can look up medication on your plan, check to see if your medication you take is on the list, and find out if your medication requires a coverage review
If a medication is not on the formulary, your provider can request prior authorization to get the medication covered. CIGNA has a process for providers to request prior authorization to get coverage for medications that are off formulary. This will take 48 to 72 hours to complete.

	Bi-Weekly Employee Contributions			
	Employee Only	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Full-Time (40 hours)	$74.43	$160.03	$154.81	$212.88
Part-Time 2 (30 - 39 hours)	$84.54	$281.64	$272.48	$374.65
Part-Time 1 (20 - 29 hours)	$178.63	$384.07	$371.56	$510.96

IMPORTANT NOTICE:

Cigna ID Cards: Your ID cards from Cigna will be Digital on mycigna.com or mycigna.app. You can also request a physical card using mycigna.com or mycigna.app to be mailed to the address on file, which will take two weeks to receive.

Pharmacy: Cigna is introducing their Member Choice Program to customers. Members have a choice between CVS or Walgreens as the anchor of their pharmacy benefits. The pharmacy that you choose is considered in-network and the pharmacy that you don't choose is considered out-of-network.

- All other remaining pharmacies are still in-network. This change only applies to choosing between CVS & Walgreens (and their affiliate pharmacies) specifically.
- Members can make an election by logging onto mycigna.com or calling Cigna Customer service

Health Savings Accounts — HSA Bank

If you elect to participate in the CIGNA High Deductible Health Plan and you are not covered under any non-qualified medical coverage, including a healthcare flexible spending account, you may be able to open a Health Savings Account. If eligible, the Village will fund an amount based on your coverage level and your initial HDHP enrollment date.

Individually Owned Account

As the owner and administrator of your Health Savings Account, you determine how much you contribute, when to use your money to pay eligible expenses, and when to reimburse yourself. An HSA allows you to save and grow your balance if you do not spend it - there is no "use it or lose it" provision with an HSA. The money in this account is always yours, even if you change health plans, change jobs, or retire.

There are Triple Tax Savings with an HSA

- Contributions, made through payroll deductions to an HSA are pre-tax
- The money in your account grows tax-free, and
- As long as the funds are used to pay for qualified medical expenses, they are spent tax-free.

Funding Limits

The IRS limits the annual amount that can be contributed to an HSA. For 2024, the maximum contributions, including any amount you contribute or The Village contributes, for these accounts are: $4,150 for single coverage and $8,300 for all other coverage levels.(Anyone age 55+ can contribute an additional $1,000 in the form of a "catch up" contribution.)

The Village Provides A Contribution to Your HSA

The Village currently provides an HSA employer contribution. Your account needs to be established with HSA Bank in order for you to receive the HSA employer contribution.

Coverage Election	Village Contribution*
Employee Only Coverage	$500
All Other Coverage Levels	$1,000

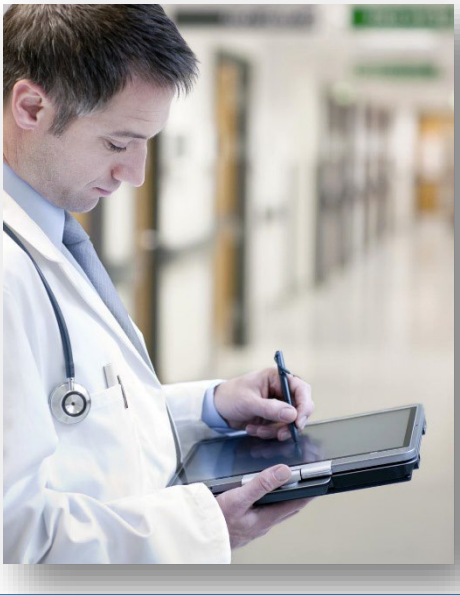
Please note that for new employees becoming eligible for benefits after 7/1/2024, the amount of the contribution will be pro-rated based on the date you become eligible for benefits and the rate tier you elect.

Telemedicine

What is MDLIVE Online?

Using MDLIVE Online, you can have a private and secure video visit with a board-certified doctor 24/7 on your smartphone, tablet or computer with a webcam. It's a quick and easy way to get the care you need with no appointments or long wait times.

There is a maximum charge up to $55 associated with each MDLIVE Online visit.



Get The Care You Need

Commonly treated medical conditions include:

- Cold & flu symptoms
- Allergies & asthma
- Bronchitis & sore throat
- Skin inflammations
- Sinus & respiratory infections
- Ear infection
- And more! (Including Pediatric Care)

MDLIVE 1.888.726.3171 www.my.cigna.com

Employee Assistance Program — Life Assistance Program through CIGNA

The help you need – when you need it most. 24/7 support, advise and resources.

- Counseling
- Legal
- Financial Planning

www.cignalap.com 1.800.538.3543 Name: Life Assistance Program

Dental Insurance — CIGNA

You are provided with the option of electing dental insurance through CIGNA.

Total CIGNA DPPO: You can obtain services from both participating and non-participating providers.

Please note: If waiving coverage upon original eligibility date and then deciding at a later date to participate, waiting periods for services will apply. See booklet for details.

Dental services are on a calendar year basis.

For a listing of participating providers visit: www.mycigna.com

Benefit	In Network	Out of Network
Deductible	$50 Individual / 3 times individual	
Preventive Care	100%	100%
Basic Care	100%	80%
Major Care	60%	50%
Annual Maximum	$1500 per person (applies to all tiers)	
Orthodontic Services	50% coinsurance to $1,500 lifetime maximum per child (Through age 18. Child must have been banded prior to their 19th birthday in order to receive coverage.)	

Bi-weekly Employee Contribution			
Employee Only	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
$8.44	$16.03	$18.90	$27.51

Vision Insurance — Anthem

The Village offers you, and your eligible dependents, vision coverage through Anthem's Blue View Vision Plan. When you receive care from a participating provider, you'll receive the greatest benefits and money saving discounts. You can also choose to seek care outside of the network, where you'll receive a pre-determined allowance toward services. Highlights of our vision program are as follows:

	Vision Plan	
Benefit	**In-Network (Member Cost)**	**Out-of-Network (Reimbursement)**
Exam (Once every calendar year)	$10 copay	Up to $30
Frames		
Frames (Once every 2 calendar years)	$130 allowance, then 20% off any remaining balance	Up to $64 allowance
Standard Plastic Lenses (Once every calendar year, lenses or contact lenses)		
Single/Bifocal/Trifocal Lenses	$10 copay	Up to $36/$54/$69
Contact Lens (Once every 12 months, lenses or contact lenses)		
Conventional	$130 allowance, then 15% off any remaining balance	Up to $105
Disposable	$130 allowance (no additional discount)	Up to $105

	Bi-Weekly Employee Contributions		
Employee Only	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$2.65	$5.04	$5.31	$7.80

Life and Disability Insurance — New York Life

Employee Basic Life, AD&D, & Dependent Life Insurance

You will receive both life and accidental death and dismemberment (AD&D) coverage for yourself, and basic life insurance for both your spouse and your children, fully paid for by The Village as outlined below.

Benefits are reduced by 35% at age 65 and by an additional 15% at age 70.

Covered Employee	Benefit
Benefit Amount	1x Your Annual Earnings
Minimum Benefit	$10,000
Maximum Benefit	$200,000

Covered Individual	Benefit
Spouse	$2,000
Dependent Child(ren)	$1,000
	15th day following birth and terminates at age 26

Supplemental Life

In addition to the group life insurance that The Village provides, you have the option of purchasing additional life insurance for yourself, your spouse and/or your child(ren). The coverage is available at group rates and through the convenience of payroll deduction. Please keep in mind that in order to enroll a spouse and/or child(ren), you must enroll yourself.

	Employee	Spouse	Dependent Child(ren)
Minimum Benefit	$10,000	$5,000	$10,000
Maximum Benefit	5x annual salary up to $300,000	50% of employee's elected benefit, up to $100,000	$10,000
Increments	$10,000	$5,000	$10,000
Guaranteed Issue	5x annual salary, up to $150,000	100% of employee's elected benefit, up to $35,000	$10,000

Voluntary Short-Term Disability

Short-term disability coverage is designed to provide you with income replacement in the event you become disabled due to a covered non-work related illness or injury. The plan will pay 60% of your weekly income up to a maximum of $1,000. A 14-day elimination period applies before benefits are payable and benefits can continue up to 24 weeks (after the waiting period.) This plan is offered to you on a voluntary basis; please see Human Resources for rate information**. This plan will pay second to CT Paid Family Leave.**

Long-Term Disability

The Village provides employees with income replacement if you are out of work due to a non-work related illness or injury after 180 calendar days. This coverage is provided at no cost to you and can pay 60% of your monthly income (up to a monthly maximum of $5,000). This benefit is fully paid for by The Village.

Flexible Spending Accounts - Inspira

(Please note, that the healthcare FSA program is not available to employees who are enrolled in our high deductible health plan and are eligible to receive and/or contribute money into a health savings account (HSA). Other restrictions may apply; please see Human Resources for more information.)

A great way to plan ahead and save money over the course of a year, is to participate in the Flexible Spending Account (FSA) program. This program allows you to redirect a portion of your salary, on a pre-tax basis, into reimbursement accounts (healthcare and/or dependent care). Pre-tax means the dollars you use for eligible expenses are exempt from social security, federal and state income taxes.

Money from your healthcare account can be used to pay medical, Rx, dental and vision expenses that have not been reimbursed by any insurance plan. Money in a dependent care account allows you to pay for dependent care expenses while you are at work. Qualifying dependents include children under the age of 13 and/or dependents who live with you who are physically or mentally incapable of self-care. (You must be able to claim these dependents on your tax return.)

Plan Maximums

For the 2024-2025 plan year, the maximum you may contribute into a healthcare account is $3,200 and the maximum you may contribute dependent care account is $5,000 ($2,500 if you are married and filing separate returns). The rollover for your healthcare account is $640.

Deadlines for Claim Reimbursement

For the 2024-2025 plan year, claims incurred between 7/1/24 and 6/30/25, can be submitted up until 9/30/25 under the 90-day run out provision. You can rollover up to $640 into the plan year. Any amount over $640 will be forfeited.

Please note the FSA vendor is Inspria Financial – formerly PayFlex.

403(b) Defined Contribution Plan

The Village 403(b) Defined Contribution Plan administered by Empower provides eligible employees the opportunity to save toward future retirement goals. 403(b) contributions are deducted from your paycheck before federal income tax is withheld. That means your taxable income is lower and you pay less in federal taxes. Eligible employees may begin participating in the Village 403(b) plan, day one (1) of employment.

All staff may contribute immediately toward your retirement through payroll deductions on day one (1) of employment or thereafter. The Village will provide a match of 100% of up to 3% of the employee's salary for staff after meeting one (1) year of service and working 1,000 hours. All newly hired staff are auto enrolled into a pretax 403b at 3% of salary. Staff can change for any pay period directly with Empower.

In addition, The Village will contribute the Defined Contribution Plan on behalf of all eligible employees, this is known as a separate, non-elective contribution. This contribution is 2% of an employee's annual salary after having met one (1) year of service & 1,000 hours.

The Village contribution and match are 100% fully vested upon attaining three (3) full years of service. Investment options are a personal choice and employees may elect their investment choices and where to invest their dollars. If you do not make an investment selections, funds will automatically default into an age-appropriate Life Cycle Fund.

For assistance in selecting and enrolling in appropriate investment allocations, contact Empower at 1-800-338-4015 or visit participant.employer-retirement.com.

Employee Assistance Program

The Village provides employees with an Employee Assistance Program through ESI, which provides confidential support services to employees and their family members. The EAP can help with:

- Relationship & family issues
- Depression, stress or anxiety
- Grief or loss of a loved one
- Eating disorders or substance abuse
- Workplace difficulties

Program features include:

Counseling Benefits – access to telephonically speak with a counselor 24 hours a day. Every counselor has a Master's or Ph.D. degree. Counselors can help make referrals to local counselors and provide work-life or wellness resources. Includes access to short-term, in-person counseling
Work/Life Benefits – assistance for financial, legal, and child & elder care
Online wellness resource center & One-on-One Wellness Coaching - with reliable articles, videos and self-assessments for dealing with stress, diet, fitness and smoking
Peak Performance Coaching - via one-on-one telephonic sessions with a Certified coach combined with structured, online trainings
Training & Personal Development Benefits – over 10,000 free online personal and professional development trainings
Self-Help Resources – access to a collection of thousands of tools, videos, financial calculators and informative articles covering every issue you might face, including adoption, relationships, legal, financial, cancer and more
Lifestyle Savings Benefit – includes thousands of discounts, rewards and perks in a variety of categories.
Personal Assistant – help for everyday issues, including finding a local medical and dental provider, summer camp options and more.

Call: (800) 252-4555
Website: www.theEAP.com

OnMed

The Five Ws

Who? Hartford HealthCare is partnering with OnMed® to pilot test new access points for healthcare in Connecticut. Visit Hartford HealthCare's OnMed Care Stations web page to learn more. Hartford HealthCare invited The Village to participate in this project.

What? OnMed® Care Stations offer walk-in (no appointment needed) telehealth services. The innovative virtual care platform that utilizes a broad range of diagnostic and interactive technologies to provide a personalized care experience. Learn more and watch a video here: OnMed – The Anywhere Healthcare Solution.

Where? Hartford HealthCare will be placing OnMed® Stations at three locations in Connecticut. The first, at Stop & Shop in Killingly, opened in early December. The second will be installed at Village South.

When? The Village and Hartford HealthCare are planning a soft launch on March 13, 2024, with an official opening marked by a ribbon-cutting slated for March 18.

Why? The Village leadership is excited to participate in this pilot project because:

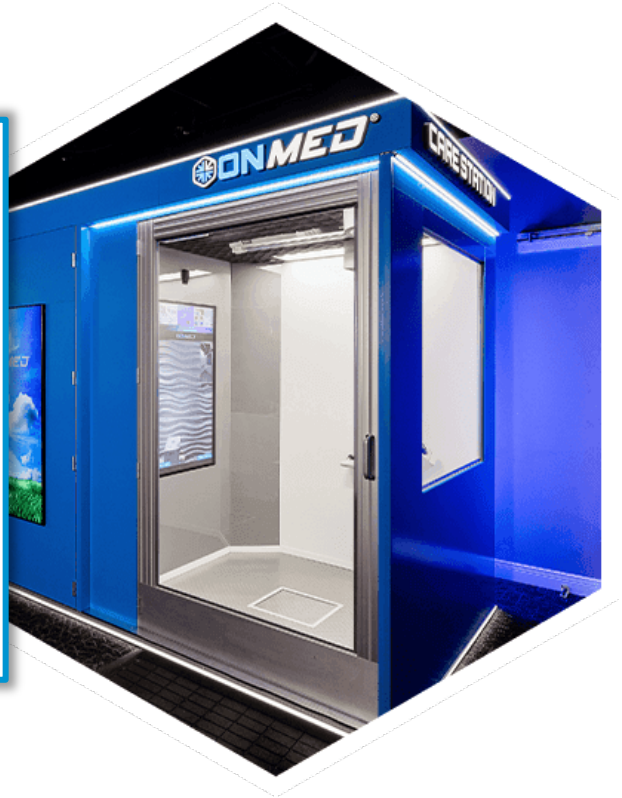
The project aligns with our strategic goal of building integrated health care partnerships for collaboration and better care. The community we serve faces multiple barriers to healthcare access, which contributes to health disparities. The pandemic accelerated changes in how some people interact with their healthcare providers. In 2021, 47 percent of adults in Greater Hartford reported having a telehealth visit, with 68 percent reporting it was as good or better than an in-person visit. This innovation has the potential to increase access to care as well as the patient experience of care. A pilot allows us to evaluate a new approach that, if successful, could be scaled up for greater impact.

What concerns can be treated at the OnMed® Station?

OnMed® is designed to meet many urgent and sick care needs. The Care Station serves patients who require medical attention for minor-to-moderate concerns, such as:

- sore throat
- sinus pain
- other common symptoms of illness, including fatigue, cough and nasal congestion
- skin rash
- eye or ear infections
- minor burn
- abdominal pain and other gastrointestinal issues

The OnMed® Station will be located in the office suite inside to the left of the main entrance. The space was previously home to Adult Services and is used as a waiting area during VITA season.

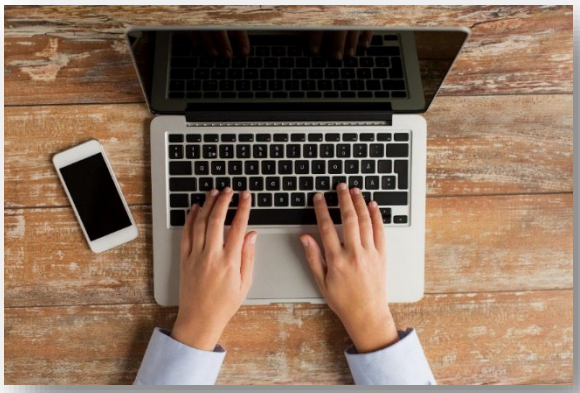


Contacts

Important Contact Information

For additional assistance, please contact the Human Resource Department.

Benefit	Provider	Phone	Website
Medical	CIGNA	1.866.494.2111	www.mycigna.com
Pharmacy	CIGNA	1.866.494.2111	www.mycigna.com
Dental	CIGNA	1.800.244.6224	www.mycigna.com
Vision	Anthem	1.866.723.0515	www.anthem.com
Life, AD&D-STD-LTD	CIGNA	1.888.842.4462	www.mycigna.com
FSA	Inspria	1.844.729.3539	www.inspirafinancial.com
HSA	HSA Bank	1.800.357.6246	myaccounts.hsabank.com/Login.aspx
Employee Assistance Program (EAP)	ESI	1.800.252.4555	www.theEAP.com
Retirement	Empower	1.800.338.4015	participant.employer-retirement.com



Every effort has been made to ensure the accuracy of the information in the Employee Benefit Overview. Plan provision summaries contain only highlights.

If there is a discrepancy between this overview and the plan documents, the plan documents will govern.

Although The Village intends to continue all benefits in their present form, they reserve the right to amend, suspend, or terminate in whole or part, any or all of the plans at anytime. If any changes are made, you will be notified promptly.

NFP Contacts

Dawn DeMatteo – Senior Account Executive, dawn.dematteo@nfp.com, 860-507-8884

Jennifer Alfano – Account Manager, jennifer.alfano@nfp.com, 860-507-8904

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Compliance Notices

NOTICE OF SPECIAL ENROLLMENT RIGHTS

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided so that you understand your right to apply for group health insurance coverage outside of the annual open enrollment period. You should read this notice regardless of whether or not you are currently covered under the Group Health Plan. The Health Insurance Portability and Accountability Act (HIPAA) requires that employees be allowed to enroll themselves and/or their dependent(s) in an employer's Group Health Plan under certain circumstances, described below, provided that the employee notified the employer within 30 days of the occurrence of any following events:

- Loss of health coverage under another employer plan (including exhaustion of COBRA coverage);
- Acquiring a spouse through marriage; or
- Acquiring a dependent child through birth, adoption, placement for adoption or foster care placement.

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 creates two new special enrollment rights for employees and/or their dependents. In addition to the special enrollment rights set forth above, all group health plans must also permit eligible employees and their dependent(s) to enroll in an employer plan if the employee requests enrollment under the group health plan within 60 days of the occurrence of following events:

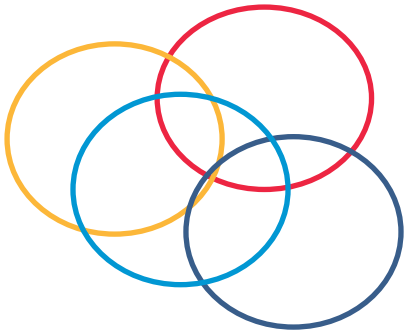
 Loss of coverage under Medicaid or a state child health plan: If you or your dependent(s) lose coverage under Medicaid or a state child health plan, you may request to enroll yourself and/or your dependent(s) in our group health plan not later than 60 days after the date coverage ends under Medicaid or the state child health plan.

 Gaining eligibility for coverage under Medicaid or a state child health plan: If you and/or your dependent(s) become eligible for financial assistance from Medicaid or a state child health plan, you may request to enroll yourself and/or your dependent(s) under our group health plan, provided that your request is made not later than 60 days after the date that Medicaid or the state child health plan determines that you and/ or your dependent(s) are eligible for such financial assistance. If you and/or your dependent(s) are currently enrolled in our group health plan, you have the option of terminating your and/or your dependent's (s') enrollment in our group health plan and enroll in Medicaid or a state child health plan.

Please note that once you terminate your enrollment in our group health plan, your dependent's (s') enrollment will be also terminated.

Failure to notify us of your loss or gain of eligibility for coverage under Medicaid or a state child health plan within 60 days, will prevent you from enrolling in our plans and/or making any changes to your coverage elections until our next open enrollment period.

To request special enrollment, or if you have questions regarding special enrollment rights, please contact the Human Resources Department.



WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to the CIGNA plan documents for details regarding the applicable deductibles and coinsurance that may apply.

If you would like more information on WHCRA benefits, please contact your Human Resources Department for more information at 860-297-0563

Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Please contact your Human Resources Department for more information at 860-297-0863.

COBRA Information

Under the Consolidated Omnibus Reconciliation Act of 1985, COBRA, the U.S. Department of Labor requires organizations that sponsor group health plans to notify individuals regarding continuation of their health care coverage under certain circumstances. You may have the option to continue your medical, dental, vision, and healthcare reimbursement coverages under COBRA continuation should you encounter a qualifying event, which would cause a loss of coverage such as, termination of employment, death of your spouse or divorce. Contact Human Resources for additional details.

NEW HEALTH INSURANCE MARKETPLACE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
The Village	06.0668594
5. Employer address	**6. Employer phone number**
1680 Albany Avenue	860.236.4511

7. City	8. State	9. ZIP code
Hartford	CT	06105

10. Who can we contact about employee health coverage at this job?
Deborah Bradley

11. Phone number (if different from above)	12. Email address
	dbradley@thevillage.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

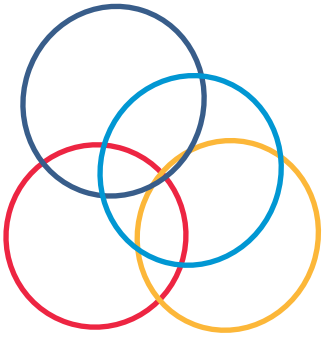
    Employees scheduled to work at least 20 hours per week.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Legally married spouses, same-sex and opposite sex domestic partners and children to age 26.
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.



MEDICARE PART D NOTICE

Important Notice from The Village About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Village about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **The Village has determined that the prescription drug coverage offered by CIGNA on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC **Updated April 1, 2011**

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CIGNA coverage maybe affected. You and your dependents can enroll in a Part D plan as a supplement to, or in lieu of, the group health plan coverage. However, if your existing prescription drug coverage is under a Medigap policy, you cannot have an existing prescription drug coverage and Part D coverage. If you enroll in Part D coverage, you should inform your Medigap insurer of that fact, and the Medigap insurer must remove the prescription drug coverage from the Medigap policy and adjust the premium as of the date the Part D coverage starts.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the CIGNA benefit plan; provided you are benefits eligible and either have a valid life status event or during an open enrollment period under CIGNA. benefit plan (or other plans available at the time).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Village and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Name of Entity/Sender:	The Village
Contact--Position/Office:	Human Resources
Address:	1680 Albany Avenue Hartford, CT 06105

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through CIGNA. changes you also may request a copy.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

CMS Form 10182-CC **Updated April 1, 2011**

NEWBORNS' AND MOTHERS' HEALTH PROTECTIONS ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact [*applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws*].

Visit [*website*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

Notes