Benefit Summary for the Employees of

New Horizons Regional Educational Centers

Effective Date:

October 1, 2017 to September 30, 2018

*This memorandum has been prepared to help you review the key factors that are associated with our benefit plans. This memorandum does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. If any differences exist between this summary and the official contracts, the contracts shall prevail.*20101110

Your Benefits Plan

New Horizons Regional Educational Centers (NHREC) is pleased to offer a comprehensive benefits program to our valued employees.

In the following pages, you will learn more about the benefits New Horizons Regional Educational Centers offers. You will also see how choosing the right combination of benefits can help protect you and your family's health and finances future.

Benefit	Carrier
Medical Insurance	Anthem Blue Cross and Blue Shield
Dental Insurance	United Concordia Insurance Company
Vision Insurance	Avesis, Inc.
Disability Insurance	Unum Life Insurance Company of America

Eligibility

All full-time employees are eligible for benefits the first of the month following your date of hire. Applications for such coverage must be completed within 30 days of employment.

In addition to electing coverage for yourself, you can elect to cover your eligible dependents. The following individuals are considered eligible dependents under the NHREC Benefits Program:

- Your legally married spouse
- Your children under age 26

The age limits do not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental or physical handicap. Coverage may be obtained or extended for a child who is beyond the age limit if you provide proof of handicap and dependence.

When Can you Enroll?

You can sign up for Benefits at any of the following times:

- After completing initial eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified family-status change

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

Making Changes

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify your employer and the change is permitted under the plan terms. Examples of these changes in status events may include:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving a Qualified Medical Child Support Order (QMCSO)

If you have a family status change, you must notify your HR Manager within 30 days in order for your requested benefit changes to be considered (60 days for Children's Health Insurance Program, CHIP). You may be required to provide documentation to support your life event change.

Medical Plans

New Horizons Regional Educational Centers offers a choice between three medical plans. You can choose the HealthKeepers 20/20 POS Open Access, the KeyCare 25 PPO or the HealthKeepers Lumenos HSA 1660 plan with Anthem Blue Cross and Blue Shield.

Anthem POS Plans

The POS plans are available to Virginia residents only. Anthem BCBS POS Plans provide cost-effective benefits when you seek care both inside and outside of the Anthem Blue Cross Blue Shield network of physicians, hospitals and other health care providers. This plan provides the most comprehensive coverage when you obtain services from participating providers. However, you do have the flexibility to see a non-participating provider for a greater cost share.

Anthem PPO Plans

The PPO plans are available to all eligible employees regardless of where they reside. The Anthem BCBS PPO Plans provide cost-effective benefits when you seek care both inside and outside of the Anthem BlueCross BlueShield network of physicians, hospitals and other health care providers. This plan provides the most comprehensive coverage when you obtain services from participating providers. However, you do have the flexibility to see a non-participating provider for a greater cost share.

Health Savings Accounts (HSA)

New Horizons Regional Educational Centers will continue to make a contribution to the HSA for those that meet the eligibility requirements. NHREC will contribute up to a maximum $1,200 for both **employee** and **employee/child** tiers and $2,200 for **employee/spouse** and **family.** NHREC will make an initial contribution of $800 for both employee and employee/child tiers and $1,400 for the other two tiers and then contribute a 50% match to employee contributions for the remainder.

The maximum allowable Employee contribution into the HSA –	2017 – $3,400 2018 - $3,450
The maximum allowable Family contribution into the HSA -	2017 – $6,750 2018 - $6,900

	PLAN COMPARISON	ANTHEM		
		HealthKeepers 20/20 OA POS Rx $150 ded. $10/30/50/20%	Keycare 25 PPO Rx $150 ded. $10/30/50/20%	GHSA 1660 POS $3,000/100%
In Network	PCP Referral Required?	No	No	No
	Deductible	No deductible	$500 - Per Member $1,000 - Family Maximum	$3,000 - Per Member $6,000 - Family Maximum
	Out-of-Pocket & Deductible Accumulator	Plan year	Policy Year	Policy year
	Office Visit	PCP - $20 copay Specialist - $40 copay	PCP - $25 copay Specialist - $50 copay	Covered in full after deductible
	Preventive Care Exam	Covered in full	Covered in full	Covered in full
	Vision Care	$15 copay for annual exam Discounts on materials	$15 copay for annual exam Discounts on materials	$15 copay for annual exam Discounts on materials
	Outpatient X-ray & Diagnostic Services	20%	20% after deductible	Covered in full after deductible
	Inpatient Hospital	20%	20% after deductible	Covered in full after deductible
	Outpatient Surgery	20%	20% after deductible	Covered in full after deductible
	Emergency Room	20%	20% after deductible	Covered in full after deductible
	Urgent Care Center	$20/$40 copay	$25/$50 copay	Covered in full after deductible
	Out-of-Pocket Maximum	$4,000 - Per Member $8,000 - Family Maximum	$4,000 - Per Member $8,000 - Family Maximum	$4,000 - Per Member $8,000 - Family Maximum
Prescription Drugs	Deductible	$150 Deductible per member * Excludes Tier 1 Prescriptions	$150 Deductible per member * Excludes Tier 1 Prescriptions	After medical deductible
	Prescriptions	Tier I - $10 copay Tier II - $30 copay Tier III - $50 copay Tier IV - 20% up to $200 per prescription maximum	Tier I - $10 copay Tier II - $30 copay Tier III - $50 copay Tier IV - 20% up to $200 per prescription maximum	Tier I - $10 copay Tier II - $30 copay Tier III - $50 copay Tier IV - 20%
	Individual Maximum	Combined with medical out-of-pocket maximum	Combined with medical out-of-pocket maximum	Combined with medical out-of-pocket maximum
Out of Network	Deductible	$750 - Per Member $1,500 - Family Maximum	$1,250 - Per Member $2,500 - Family Maximum	**$6,000 - Per Member** **$12,000 - Family Maximum**
	Coinsurance	30% after deductible Balance billing may apply	40% after deductible Balance billing may apply	30% after deductible Balance billing may apply
	Out-of-Pocket Maximum	$5,000 - Per Member $10,000 - Family Maximum	$5,500 - Per Member $11,500 - Family Maximum	**$10,000 - Per Member** **$20,000 - Family Maximum**

To search for an Anthem network provider, visit: www.anthem.com
If you have any questions about availability, you can call Anthem Blue Cross Blue Shield at: 1-800-451-1527

Prescription Overview

Mail Order

Prescriptions filled through Anthem's mail order program cost 2.5 times the retail copayment on all tiers.
Prescriptions filled by Express Scripts mail order service are for a 90-day supply.

- By phone: call 866-281-4279 M-F 8:30am to 8 pm EST to get your free cost-savings estimate.
- By mail: call the Customer Care number on your member ID card or download a form from www.anthem.com. Print the form and mail your completed order form, original prescription and payment information to:

  Home Delivery Pharmacy
  PO Box 66785
  St Louis, MO 6366-6785

- By fax: have your doctor fax your prescription information to 800-600-8105. The prescription must be faxed directly from your doctor's office.

90 Day Supply at Retail Pharmacy

You may now fill a 90 days supply of your maintenance medication at a retail pharmacy. You will continue to pay the full cost of each prescription filled.

For Your Safety

Anthem Blue Cross Blue Shield is required to follow FDA and manufacturer dispensing rules and regulations in order to ensure patient safety. Please review the Anthem Blue Cross Blue Shield Drug Formulary for dosage limits, quantity limits and for prescriptions that require pre-certification/prior approval.

Generic Prescriptions

Many pharmacies such as Wal-Mart, Target, and Rite-Aid have generic prescription programs available for as little as $4 for a 30-day supply.

Tobacco Cessation Medications

Certain prescriptions and nicotine replacement products are covered in full (no cost to you). Check Anthem.com to find a list of applicable products, then talk to your doctor to see if one of those medications / products would be good for you. You'll need a prescription for each one (including over the counter products) in order for these to be covered at no cost.

Value Added Services

The following Value Added Services are available only to NHREC employees and dependents who participate in the Anthem BCBS health insurance plan.

LiveHealth Online

LiveHealth Online provides 24/7 access to see a physician from anywhere you have internet connection. This program was designed to handle many non-urgent matters such as: cold and flu symptoms, allergies, sinus infections, and bronchitis.

To take advantage of the benefit, you will need access to a webcam or another similar video streaming such as: Facetime or Skype. Visit www.livehealthonline.com or download the mobile app.

Members will have the following copays for LiveHealth Online and the copays are paid at the time of the call.

- $10 copay if enrolled in the HealthKeepers 20/20 OA POS plan
- $25 copay if enrolled in the KeyCare 25 PPO plan
- $49 copay if enrolled in the GHSA 1660 plan

24/7 NurseLine

Round the clock access to health information can really help your peace of mind and your physical well- being. Anthem has registered nurses available to assist you via phone with general health issues any time of the day or night.

Future Moms

If you are pregnant, we know your goal is to have a safe delivery and a healthy baby. Anthem's Future Moms program helps you make healthy choices while you are pregnant and when you deliver your baby. Register for Future Moms and you will get:

- ✓ 24/7 toll-free access to a registered nurse who'll answer your questions about pregnancy related issues
- ✓ A helpful book: Your Pregnancy Week-by-Week and maternity care diary
- ✓ Tips and facts to help you handle any unexpected events
- ✓ A questionnaire to see if you are at risk for preterm delivery
- ✓ Useful tools to help you, your doctor, and your Future Moms nurse track your pregnancy and spot possible risks

ConditionCare

If you or a covered family member has an ongoing illness or health problem, let Anthem help you get more out of life. The ConditionCare nurses gather information from you and your doctor then create a personalized plan for your specific needs.

To reach the 24/7 Nurseline or for more information on Future Moms or ConditionCare call the customer service number on the back of your Anthem ID Card.

Estimate your Cost Tool

Did you know that different hospitals and facilities charge different amounts for the same services? Now you can know your cost before you set foot in the hospital. By getting an estimate of your costs based on the benefits of your health plan, you can choose a facility that fits your budget. Visit anthem.comd and select Estimate Your Cost to begin your search.

Dental Plans

Benefit eligible employees and their dependents may enroll in the dental benefits provided through United Concordia Insurance Company. Although you can go to any dentist you wish, your plan year maximum will stretch farther if you go to a Preferred Provider who offers discounts on their usual fees. If you go to a non-participating provider, you will need to submit your claims to United Concordia Insurance Company. To find a United Concordia Insurance Company provider, call the number listed on the back of your ID card.

BENEFITS SUMMARY OF SERVICES	United Concordia
Annual Deductible	
Individual	$25
Family	$75
Annual Maximum Benefit:	**$1,500**
Diagnostic/Preventive Care	**Plan Pays:**
Oral Examinations	100%
X-Rays	100%
Sealants	100%
Palliative Treatment (Emerg relief for pain)	100%
Cleanings	100%
Topical Flouride Treatment	100%
	DEDUCTIBLE APPLIES
Basic Dental Services	**Plan Pays:**
Basic Restorative (Fillings)	80%
Non-Surgical and Surgical Periodontics	80%
Simple extractions	80%
Complex Oral Surgery	80%
Endodontics (Root canal therapy)	80%
Repairs of Crowns, Inlays, Bridges, Dentures	80%
General Anesthesia and/or IV Sedation	80%
Major Services	
Inlays	50%
Crowns	50%
Prosthodontics	50%
Dentures	50%
Out of Network Reimbursement	**MAC**
Notes:	Includes Pregnancy Benefit Includes Smile for Health - Wellness Includes Preventive Incentive

DENTAL ENHANCEMENTS

- ✓ Preventive Incentive – All covered diagnostic and preventive dental services do not count toward your annual plan maximum.
- ✓ Smile for Health – Wellness – Enhanced benefits for members that have at least 1 of the 7 chronic illnesses covered and periodontitis (gum disease). See flyer for more information and how to register.
- ✓ Pregnancy Benefit – Covers additional benefits during pregnancy.

VOLUNTARY PRE-AUTHORIZATION

In the event you need to have dental work estimated to cost $300 or more, we recommend you have your dentist submit the charges to United Concordia Insurance Company for pre-authorization. United Concordia Insurance Company will review the intended treatment plan and let your dentist know how much of the bill they will cover. We recommend this to avoid any billing issues.

UNITED CONCORDIA® DENTAL

Vision Benefits

Vision benefits are available for you and your family through Avesis, Inc.. Although you can go to any vision provider you choose, go to a Avesis, Inc. provider for the highest level of coverage.

New Horizons Regional Education Ctr.

An In-Depth Look

Reliable & Dependable

Avēsis is a national leader in providing exceptional vision care benefits for millions of commercial members throughout the country. The Avēsis vision care products give our members an easy-to-use wellness benefit that provides excellent value and protection.

Employee Paid Rates Per Month

Employee	$8.99
Employee + Spouse	$15.73
Employee + Child(ren)	$16.62
Employee + Family	$23.36

Underwritten by: Fidelity Security Life Insurance Company, Kansas City, MO Policy #: VC-16, Form M-9059

Vision Care Services	In-Network Member Benefits	Out-of-Network Reimbursement
Eye Examination	Covered in full after $0	Up to $35.00
Materials: $0 copayment	(Materials copay applies to frame or spectacle lenses, if applicable.)	
Frame Allowance*	Members receive a $50 wholesale allowance Up to $150 retail value†	Up to $45.00
Standard Spectacle Lenses		
Single Vision	Covered in full after materials copay	Up to $25.00
Bifocal	Covered in full after materials copay	Up to $40.00
Trifocal	Covered in full after materials copay	Up to $50.00
Lenticular	Covered in full after materials copay	Up to $80.00
Standard Progressives	Covered up to $50, plus 20% off retail	up to $40.00
Other Lens Options‡ Lens Options are discounted up to 20% off retail		
Contact Lenses§ (In lieu of frame and spectacle lenses)		
Elective	$130 allowance	$130.00
Medically Necessary	Covered in full	$250.00
Refractive Laser Surgery	Provider discount up to 25% One-time/lifetime allowance of $150	$150.00
Frequency		
Eye Examination	Once every 12 Months	Once every 12 Months
Lenses or contact lenses	Once every 12 Months	Once every 12 Months
Frame	Once every 24 Months	Once every 24 Months

‡ Discounts are not insured benefits
§ Prior authorization is required for medically necessary contacts.

How can we help you?

Avēsis Website:
www.avesis.com

Customer Service:
800-828-9341
7 a.m. - 8 p.m. EST

LASIK Provider:
877-712-2010

Here's How It Works

When you need to see an eye care professional, simply visit www.avesis.com or contact Avēsis' Customer Service Monday through Friday, 7 a.m. to 8 p.m. (EST) at 800-828-9341 to receive a listing of providers in your area.

1	2	3	4
Select a provider	Make an appointment	Visit provider for service	Pay any copays or additional expenses

† Values provided may be more or less depending on the providers retail pricing.
* At participating Walmart locations, retail pricing for your plan is $68. At participating Costco locations, retail pricing is $54.99.

Disability Benefits

Virginia Local Disability Program (VLDP)

Political subdivision and school employees participating in the Hybrid Retirement Plan are automatically enrolled in the VLDP Short-Term Disability plan. You are eligible for benefits under this plan for work-related claims on your first day of coverage. Non-work related claims have a one-year waiting period.

If your claim for short-term disability is approved, the benefit will begin on the eighth day of your disability. If you work 20 hours or less during the first seven days of your disability, you will have satisfied the elimination period. Employees with a catastrophic or major chronic condition may have the seven-calendar day elimination period waived.

Days of Income Replacement: Non-Work Related Disability

Months of Continuous Service with Your Current Employer	Workdays at 100% Income Replacement	Workdays at 80% Income Replacement	Workdays at 60% Income Replacement
0-12	0	0	0
13-59	0	0	125
60-119	25	25	75
120-179	25	50	50
180 or more	25	75	25

Days of Income Replacement: Work-Related Disability

Months of Continuous Service with Your Current Employer	Workdays at 100% Income Replacement	Workdays at 80% Income Replacement*	Workdays at 60% Income Replacement*
Less than 60	0	0	125
60-119	85	25	15
120 or more	85	40	0

** Contact your human resource office about leave policies and income replacement during periods of work-related short-term disability.*

UNUM Disability

To provide salary protection when the unexpected occurs, a disability benefits program is provided to all eligible employees. Costs vary as you can customize certain aspects to suit your needs.

	Unum Disability
Elimination Period	
Accident	Choice of 0, 30 or 90 days
Sickness	Choice of 3, 30 or 90 days
Benefit Features	
Monthly Benefit Amount	66.67% of earnings up to $7,500 per month
Maximum Benefit Duration	2 years ADEA
Pre-Existing Condition Limitation	12 months for conditions treated within the 3 months prior to effective date of coverage

*Please see Human Resources for rates.

Monthly Premiums

Refer to the table below for monthly employee contributions as of October 1, 2017

Employee Monthly Contribution	Anthem HealthKeepers 20/20 POS	Anthem KeyCare 25 PPO	Anthem HK GHSA 1660 POS
Employee	$50.00	$126.00	$15.00
Employee & Spouse	$175.00	$426.00	$64.00
Employee & Child	$135.00	$303.00	$30.00
Family	$250.00	$567.00	$108.00

Employee Monthly Contribution	United Concordia Dental Insurance
Employee	$0.00
Employee & Spouse	$27.30
Employee & Child	$13.86
Employee & Children	$30.00
Family	$59.56

Employee Monthly Contribution	Avesis, Inc. Vision
Employee	$10.79
Employee & Spouse	$18.88
Employee & Child(ren)	$19.94
Family	$27.98

Important Benefit Terms

Understanding these important terms will make it easier to receive the greatest benefit from NHREC Benefits Program.

Coinsurance – A provision that requires a covered person to share in the cost of health care services. It is the specific percentage that the covered person must pay for certain eligible expenses until the out-of-pocket limit is reached.

Copay – A fixed, up-front dollar amount that the covered person may be required to pay for certain covered services such as office visits when using In-Network providers. The amount paid does not vary with the cost of the services. The amount is due at the time of service.

Dependents – All eligible members of the member's family that are enrolled in your coverage.

Deductible – The amount that you must pay out of your own pocket for certain eligible expenses before a plan will begin to pay all or a portion of those expenses.

Emergency – An accidental injury or the sudden and unexpected onset of a condition posing significant life-threatening circumstances – jeopardizing your health – and requiring immediate medical or surgical care. For instance, a heart attack, stroke, poisoning, major fractures, convulsions, or loss of consciousness or respiration would qualify as emergencies.

In-Network – Hospitals, physicians, and other health care providers who have been screened, selected, and have agreed to participate in a preferred provider network. In joining the network, health care providers must meet standards for quality and efficiency, and demonstrate a commitment to providing the most appropriate care at the most reasonable cost.

In-Patient – A person admitted to the hospital or facility, receiving hospital services including room, board and general nursing care, for longer than one day.

Insured – The member entitled to benefits under a contract by virtue of his/her relationship to the group contract holder. Also known as a covered person.

Managed Care – Health programs that use a select group of health care providers to ensure that you receive the most appropriate care at the most reasonable cost

Out-of-Pocket Maximum – The most you can pay during a covered period for your share of health care services.

Pre-Admission Certification – Provision within the medical plan that requires you or your family member to contact the carrier for services such as hospital admissions, outpatient services, surgery or maternity admission. Check your certificate of coverage for other pre-admission requirements.

Pre-Tax Benefits- Benefits deducted from your pay on a pre-tax basis in accordance with IRS Section 125. Pre-tax elections for health and welfare benefits (excluding 401k) are irrevocable within the calendar year for which they are made unless you experience a Mid-Year Qualifying Event.

Primary Care Physician (PCP) – A physician, generally a family doctor, internist, general practitioner or pediatrician who provides all "primary" (general) medical care.

Specialist – A physician with advanced training and knowledge in a particular branch or medicine or surgery. (i.e. Cardiologist – heart disorder, Gastroenterologist – stomach and intestine disorders, etc.)

Other Benefits

Flexible Spending Accounts
Under Section 125 of the Internal Revenue Service Code, certain medical and dependent care expenses can be paid for on a pre-tax basis if the employee makes an election each year to do so. This plan allows the employee to set aside up to $2,500 per year for eligible medical expenses and up to $5,000 per year for eligible day care or aged adult care expenses. (These are out-of-pocket medical expenses and dependent care expenses not covered by any insurance benefits.) The elected amount is deducted directly from each paycheck for 9 months. $500.00 can be carried over to the following year if you re-enroll. This plan is administered by Flexible Benefit Administrators.

You also have the option to elect the Benny Card (debit card) to pay for your eligible medical expenses that is deducted straight from your account. In some instances you may still be required to submit a receipt to the IRS to prove your claim was an eligible expense.

Note: A new enrollment form must be completed during open enrollment each year to continue in this plan.

Legal Resources:
Legal Resources protects New Horizon's employees from the high cost of attorney fees by providing legal services and courtroom representation. **As a member, you are covered for expected and unexpected legal needs**, including real estate closings, will preparation, traffic matters, divorce and much more. Most attorneys charge between $200-400 per hour, but as a Legal Resources member, you and your family are covered for $19 per month.

Virginia Retirement System:
The Virginia Retirement System (VRS) administers a statewide multiple-employer public employee retirement system providing defined benefits pension plan coverage for state employees, teachers, and non-professional employees of public school boards. All full-time contracted employees are eligible for VRS membership. Active members of VRS may be eligible to purchase prior service credit.

VRS has three plan provisions.

***Plan 1* -** if your membership date is before July 1, 2010 and you were vested (you had at least five years of service credit) as of January 1, 2013. Members will be required to make a 5% member contribution.

Plan 2 - if your membership date is July 1, 2010 or later, or if your membership date is before July 1, 2010 and you were not vested as of January 1, 2013. Members will be required to make a 5% member contribution.

VRS Hybrid – if your membership date is January 1, 2014 and beyond. Members are required to make a 4% contribution to the VRS Defined Benefit Plan and a 1% contribution to the Defined Contribution Plan managed by ICMA-RC (employees may make additional optional contributions to this plan through ICMA-RC).

For more information regarding retirement, visit http://www.varetire.org or call 1-888-827-3847.

403(b) Investment Plan:
A 403(b) is an optional supplemental retirement plan. The employee makes the full contribution through payroll deduction on a pretax basis. Employees can enroll at anytime with MetLife representative, Sung Mi Kim, 757-873-2448, or Valic representative, Brian Schwabe, 757-876-8406.

Life Insurance:
Eligible employees are automatically enrolled in life insurance through the Virginia Retirement System (VRS). NHREC pays the total premium for these employees. The plan provides group term insurance protection to your designated beneficiary(ies) in the event of your death while covered by the Plan. Coverage is determined by rounding your annual salary up to the next $1,000 then doubling it. (i.e. a salary of $10,100 would be rounded to $11,000 and doubled for coverage of $22,000).

When you retire, your basic group life insurance coverage continues at no cost to you provided you are at least 55 years of age and have at least five years of service, or are 50 years of age with at least 10 years of service. In both cases you must have at least five continuous years as an employee, within the state system, immediately prior to termination of service. After retirement, the amount of your insurance reduces by 25 percent annually starting January 1 of your first full year following retirement, until your coverage reaches 25 percent of its value at your retirement.

Optional Life Insurance:
All full time employees covered by Virginia Retirement System are eligible to purchase Optional Life Insurance. The rates are based on your age and salary. If you are interested, please contact the Benefits Office for additional information.

Worker's Compensation:
All employees are covered by worker's compensation insurance in case of a "job related injury" and in some cases the employee may be covered under Short Term Disability. This may include injuries occurring on or off the premises, if one is on official business for NHREC. It does not usually include injuries sustained while going to and from your place of employment.

Employee Assistance Program (EAP):
The EAP is a confidential program that provides employees and eligible family members with assessments and short-term problem resolution at no cost. No information about participation in the program will be released to anyone without written consent unless otherwise specified by state and federal laws. The EAP can be reached 24 hours a day, 7 days a week at (800) 346-5484 or www.anthemeap.com. To access the website use the Log-in: NewHorizons.

Tuition Reimbursement:
New Horizons may pay up to $550 for one successfully completed class per year based on the actual cost of the class. The Center may pay up to $1,000 for the cost of one to three classes per year for the initial certification/academic credentialing in the position held, based on the cost of each class. Reimbursement of all requests are dependent on there being sufficient funds in the budget. Reimbursement of classes will also be paid on an "as received" basis in the Finance Office. Employees must commit to at least one additional semester after being reimbursed for tuition; otherwise the money must be paid back to NHREC.

Adult Education:
All full-time employees are eligible to take a New Horizons Adult Education class free of charge on a space available basis. Please contact the Adult Education Office at 766-1101 for further details.

Sick Leave:
On the first day of employment, full-time and part-time (contracted) employees will be granted one half of annual sick leave allowance. Employees will be granted the other half of sick leave allowance the beginning of February. An unlimited number of sick leave days may be accumulated. Sick leave will be charged as taken.

12 month employees: allowed 15.6 sick days annually
11 month employees: allowed 14.3 sick days annually
10 month employees: allowed 13.0 sick days annually
Half-time contracted employees: earn 6.50 sick days annually

Effective July 1, 2015, there will no longer be a payout of sick leave upon termination unless the employee is retiring (please refer to the retirement section below).

Personal Leave:
The sick leave policy provides that three days of sick leave may be used for personal leave during the year. Personal leave allowance is not cumulative and must be approved in advance by the Supervisor. Personal leave requests must be submitted at least three (3) days prior to the requested leave date or can be taken for authorized emergency use only.

Employees who have accrued at least 40 days of sick leave at the beginning of the contract year may use up to four (4) days per year for personal leave.

Sick Leave Donation:
This is a voluntary program to assist New Horizons employees unable to work due to a non-job related injury, temporary disability, illness or incapacity of a family member. The injury, disability, illness or incapacity must be the result of an unforeseen medical emergency of a serious nature and in the opinion of a licensed physician, is expected to last at least 20 consecutive working days after all accrued paid leave is exhausted. Guidelines governing the Sick Leave Donation Program are available through the Human Resources Department.

Twelve-Month Employee Vacation:
All full time employees will be eligible for paid vacation according to the following provisions:

0-5 years employment	1 day per month
6-10 years employment	1 1/4 day per month
11-14 years employment	1 ½ day per month
15+ years employment	2 days per month

Vacation accrues based on employment as a 12 month employee at NHREC. February 1st of each year, 12 month employees will have the option of converting vacation days in excess of 36 days, to their sick leave balance. Once the request is approved, it cannot be changed back to vacation. Upon termination or retirement, any converted leave will be treated as sick leave. Vacation accumulation cannot exceed 36 days.

Delayed Pay:
A delayed pay account can be set up that will allow 10 month and 11 month employees to stretch their paychecks into 12 installments. 10 month employees must sign up by the end of August and for 11 month employees, by the end of July to participate in the delayed pay program. You must join Hampton Roads Educator's Credit Union to participate. HRECU is the only credit union that offers delayed pay.

Retirees:
Employees hired after July 1, 2015, will no longer utilize sick leave to purchase health insurance. Those eligible to purchase group health insurance that is offered through NHREC and elect to receive it, will receive it until the employee is eligible for Medicare. In addition the retiree must have a minimum of 24 months participation in the health care/hospitalization insurance program prior to their retirement date. If the employee was not participating in the health insurance option, it may not be added at retirement.

Retirees eligible to apply accrued sick leave as credit toward NHREC's contribution for "single employee" coverage, will be based on the Anthem BlueCross BlueShield cost. NHREC will pay the allowable percentage of its contribution until the retiree is eligible for Medicare. The retiree pays the employee cost plus the remaining percentage of NHREC contribution. A retiree may opt for family coverage and/or other available plans but will assume additional cost or savings. Sick leave can also be used to purchase VRS service credit, see HR for details.

# of Sick Leave Days Earned	Employee Only Coverage[1]
1 – 49	0%
50	50%
100	65%
150	80%
200	100%

[1] Retiree is responsible for 100% of the cost retiring with 1 – 49 sick leave days

Upon retirement, employees may request payment of $30.00 per day for unused sick leave accumulated at NHREC, with a maximum payout of $5,000.00.

This summary is not meant to interpret, extend, or change the terms of the Plan in any way. In case of a conflict between this summary and the actual provisions of the Plan, the provisions of the Plan will govern employee rights and benefits. Although it is intended that the Plan be maintained indefinitely, the Board of Trustees reserve the right to amend or terminate the Plan in whole or in part at any time.

For additional information contact:
New Horizons Regional Education Centers
Attention: Human Resources Department
520 Butler Farm Road
Hampton, VA 23666
(757) 766-1100

Contact Information

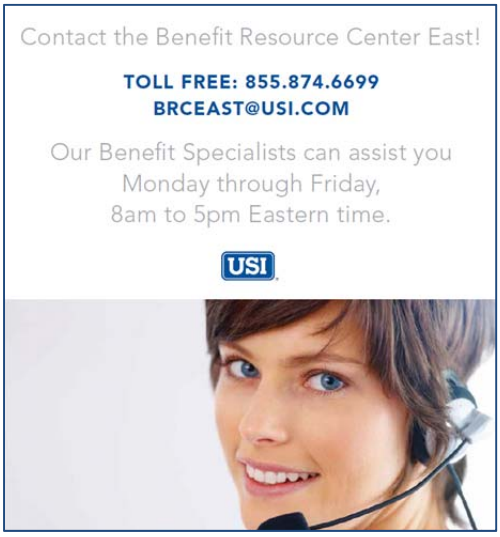
If you have any further questions concerning your benefits, please contact:

Carrier	Plan	Website	Phone Number
Anthem Blue Cross and Blue Shield	Medical Plan	http://www.anthem.com	(855) 333 - 5735
United Concordia Insurance Company	Dental Plan	http://www.UnitedConcordia.com	(800) 332 - 0366
Avesis, Inc.	Vision Plan	http://www.avesis.com	(800) 828 - 9341
Unum	Disability Plan	http://www.unum.com	(866) 679 - 3054

Benefit Resource Center

The Benefit Resource Center is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time via phone 855-874-6699 or via e-mail BRCEast@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.



Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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. For further details, please refer to your summary Plan Description of Summary of Benefits and Coverage (SBC).

NEWBORNS ACT DISCLOSURE - FEDERAL

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).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

Anthem generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem Member Services at (855) 333 – 5735.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem Member Services at (855) 333 – 5735.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Carol Porter
520 Butler Farm Road
Hampton, Virginia United States 23666
757-766-1100 ext3358
carol.porter@nhrec.org

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- 10/01/2017
- Carol Porter
  757-766-1100 ext3358
  carol.porter@nhrec.org

Important Notice from New Horizons Regional Education Centers 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 New Horizons Regional Education Centers and 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. **New Horizons Regional Education Centers has determined that the prescription drug coverage offered by the HealthKeepers 20/20 OA POS, KeyCare 25, or GHSA 1600 plan is, 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 15thto 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.

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 New Horizons Regional Education Centers coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current New Horizons Regional Education Centers coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

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 New Horizons Regional Education Centers 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 This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through New Horizons Regional Education Centers changes. You also may request a copy of this notice at any time.

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).

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).

Date:	10/01/2017
Name of Entity/Sender:	New Horizons Regional Education Centers
Contact--Position/Office:	Carol Porter
Address:	520 Butler Farm Road Hampton, VA 23666
Phone Number:	(757) 766 – 1100 ext 3358

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, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Centerr: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, 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
Centerrs for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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OMB Control Number 1210-0137 (expires 12/31/2019)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 4-30-2017)

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 Carol Porter in 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.

[1] An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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 New Horizons Regional Educational Center	4. Employer Identification Number (EIN) 54-0974022	
5. Employer address 520 Butler Farm Road	6. Employer phone number 757-766-1100	
7. City Hampton	8. State VA	9. ZIP code 23666
10. Who can we contact about employee health coverage at this job? Carol Porter		
11. Phone number (if different from above)	12. Email address Carol.porter@nhrec.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 working at least 30 hours per week. Employees working less than 30 hours and any temporary or seasonal employees are excluded.
- With respect to dependents:
  - ■ We do offer coverage. Eligible dependents are:

    Dependents of eligible employees described above.
  - ☐ 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.

• An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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