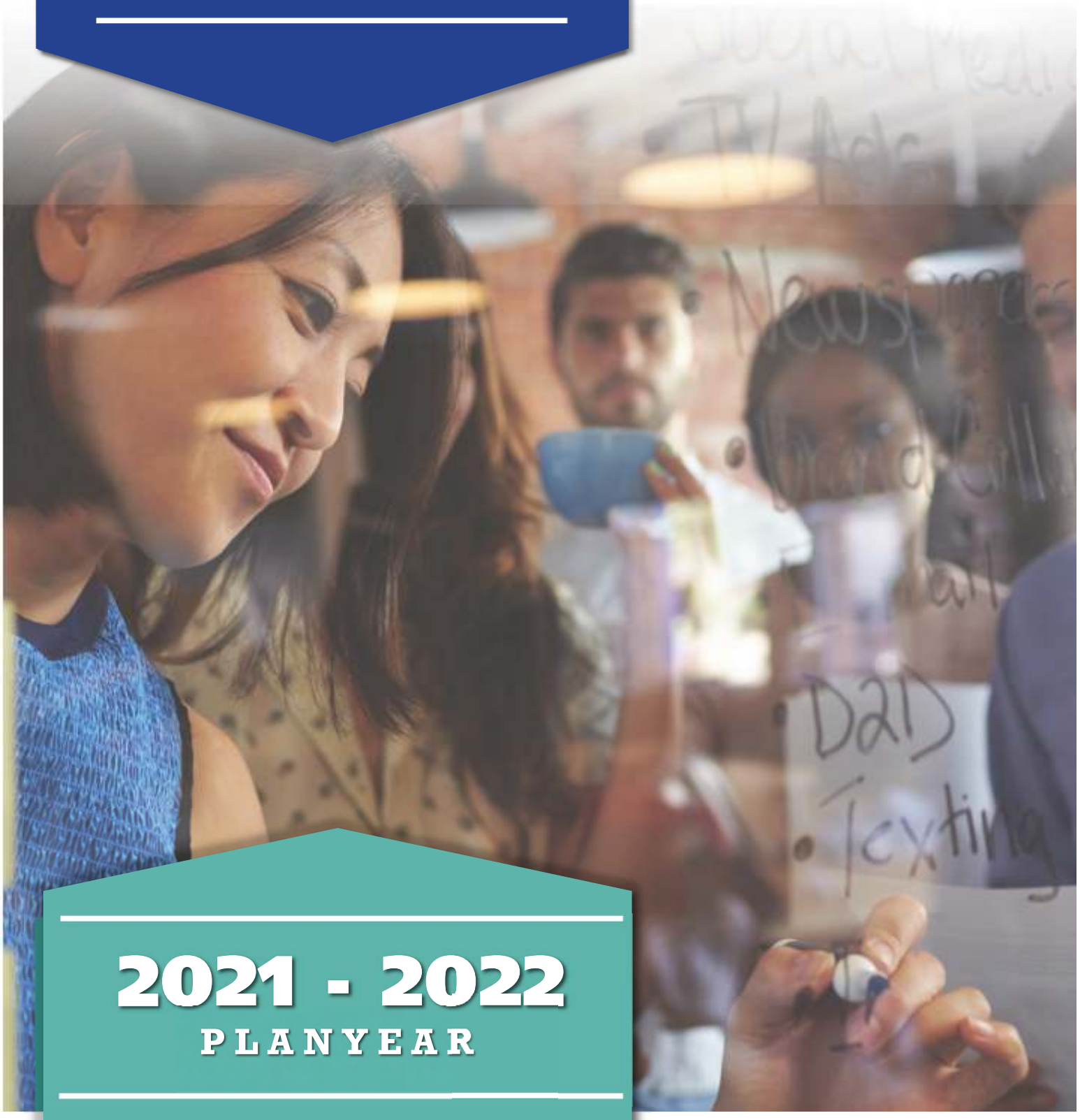
EMPLOYEE BENEFITS GUIDE

New Horizons
REGIONAL EDUCATION CENTERS



2021 - 2022
PLAN YEAR

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Welcome

At New Horizons Regional Education Center, we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

Sincerely,

New Horizons Regional Education Center HR

Contact Information

Have Questions? Need Help?

New Horizons Regional Education Center is excited to offer access to the USI Benefit Resource Center (BRC), which 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 at 855-874-6699 or via e-mail at 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.

Additional information regarding benefit plans can be found below. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service

	CARRIER	PHONE NUMBER	WEBSITE
Medical	Optima Health Insurance Company	(800) 275-3755	www.OptimaHealth.com
Dental PPO	United Concordia Insurance Company	(800) 332-03266	www.unitedconcordia.com
Vision	Avesis, Inc.	(844) 630-1100	www.avesis.com
Long Term Disability (LTD)	Unum Life Insurance Company of America	(800) 421-0344	www.unum.com
Employee Assistance Program (EAP)	Optima Health Insurance Company	(757) 363-6777	www.OptimaEAP.com
Legal Resources	Legal Resources	(800) 728-5768	www.legalresources.com
USI's Benefit Resource Center	USI's Benefit Resource Center	(855) 874-6699	BRCEast@usi.com

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

USI®

Benefit Resource Center

BRCEast@usi.com | Toll Free: 855-874-6699

Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

Eligibility

Eligible Employees:

You may enroll in the New Horizons Regional Education Center Employee Benefits Program if you are an employee working at least working at least 30 hours per week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents may be as well. In general, eligible dependents include your spouse and children up to age 26. Children may include natural, adopted, stepchildren and children obtained through court- appointed legal guardianship.

When Coverage Begins:

The effective date for your benefits is October 1, 2021 Newly hired employees and dependents will be effective in New Horizons Regional Education Center's benefits programs. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status event.

Enrollment

Enrolling in benefits is simple!

1. To learn about the benefits available to you, attend benefits orientation and review your benefit guide.
2. Obtain enrollment forms from Human Resources.
3. Complete forms, electing benefits applicable to you and your family.
4. Return completed forms to Human Resources.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

2021 Optima Mandated Plan Changes

Mid-Market and Large Group Plans

Optima Health

Benefit Changes

The following changes apply to groups effective or renewing on or after January 1, 2021

All Plans

Balance Billing[1]

- Virginia out-of-network providers cannot balance bill members for:
  - emergency services, regardless of the final diagnosis
  - non-emergency surgical and ancillary services provided at an in-network facility
- Members pay in-network deductibles, and copayment/coinsurance amounts are credited to in-network maximum out-of-pocket amounts.

The Inpatient Hospital Services and Transplants benefits will be listed separately on **every plan**. Previously, some plans only listed Inpatient Hospital Services with notes referencing transplants. Please note: this is a language update only.

The Skilled Nursing Facilities/Services benefit will have a 90-day limit for all plans. Previously, some plans had a 100-day limit.

The Skilled Nursing Facilities/Services benefit language has been updated to now show the cost-share amount. On some plans, it previously showed *After Inpatient Hospital Copayment or Coinsurance is met No Charge* language.

Vision Therapy is now covered for acquired convergence insufficiency and congenital convergence insufficiency.

- pre-authorization required
- twelve-visit limit

Applied Behavior Analysis (ABA) is covered as a treatment for Autism Spectrum Disorder. The $35,000 annual maximum limit for ABA services has been removed from all plans.

2021 Optima Mandated Plan Changes

Any Physical, Occupational, Speech or other therapy visit limits do not apply to treatment for Autism Spectrum Disorder.

Pre-Authorization is not required for the **inter-hospital transfer of a newborn infant** experiencing a life-threatening emergency condition or a hospitalized mother of such newborn infant to accompany the infant.

Formula and enteral products prescribed for inherited metabolic disorder are now covered. This includes equipment, supplies, and services. Pre-Authorization is required for medical equipment, supplies, and services to administer formula or enteral nutrition products.

For Pharmacy plans, Tier 3 drugs will only list a copayment and remove the "or 20% whichever is greater" language.

Mail order Tier 4 specialty drugs will be offered at the same cost share as retail and will be limited to a 31-day supply.

The member **cost sharing for insulin** has a $50 maximum copayment per 30-day supply per prescription, regardless of the amount or type of insulin required to fill the prescription.

Select risk-reducing medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects are covered at 100% under preventive care services[2].

Select **Pre-Exposure Prophylaxis (PrEP)** with effective antiretroviral therapy medications for persons who are at high risk of human immunodeficiency virus (HIV) acquisition are covered at 100% under preventive care services[2].

For groups who have an Equity or Design RxDed plan that includes the Preventive Rx benefit, **Selective Serotonin Reuptake Inhibitors (SSRIs)** medications are covered before the deductible applies for members with a diagnosis of depression, per section 223(c)(2) of the Internal Revenue Service Code[2].

[1]*Optima Health cannot automatically opt-in self-funded groups. Self-funded groups must speak with their sales representative to opt in.*

[2]*Self-funded groups have the option to implement changes at next annual renewal.*

Medical

New Horizons Regional Education Center will offer medical coverage through Optima. The chart on the following page is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

	HMO Vantage 500/20/20%	HMO Equity Vantage (HSA) 3000/0%	POS 500/20/20%	
	In-Network Benefits	In-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible				
Individual	$500	$3,000	$500	$1,000
Family	$1,000	$6,000	$1,000	$2,000
Coinsurance	80%	100%	80%	60%
Maximum Out-of-Pocket*				
Individual	$4,500	$5,000	$3,000	$8,000
Family	$9,000	$10,000	$6,000	$16,000
Physician Office Visit				
Primary Care	$20 copay	100%	$20 copay	60% after deductible
Specialty Care	$40 copay	100%	$40 copay	60% after deductible
Preventive Care				
Adult Periodic Exams	100%	100%	100%	60% after deductible
Well-Child Care	100%	100%	100%	60% after deductible
Diagnostic Services				
X-ray and Lab Tests	80% after deductible	100% after deductible	80% after deductible	60% after deductible
Complex Radiology	80% after deductible	100% after deductible	80% after deductible	60% after deductible
Urgent Care Facility	$40 copay	100% after deductible	$40 copay	60% after deductible
Emergency Room Facility Charges*	80% after deductible	100% after deductible	80% after deductible	80% after deductible
Inpatient Facility Charges	80% after deductible	100% after deductible	80% after deductible	60% after deductible
Outpatient Facility and Surgical Charges	80% after deductible	100% after deductible	80% after deductible	60% after deductible
Retail Pharmacy (30 Day Supply)				
Prescription Deductible	$150 / $300	Combined with medical	$150 / $300	$150 / $300
Generic (Tier 1)	$15 copay	$15 copay after deductible	$15 copay after deductible	$15 copay after deductible
Preferred (Tier 2)	$60 copay after deductible	$60 copay after deductible	$60 copay after deductible	$60 copay after deductible
Non-Preferred (Tier 3)	$80 copay after deductible	$80 copay after deductible	$80 copay after deductible	$80 copay after deductible
Preferred Specialty (Tier 4)	80% after deducible up to $250 per prescription	80% after deducible up to $250 per prescription	80% up to $250 per prescription a after deductible	80% after deducible up to $250 per prescription

Optima Value Added Benefits

EMERGENCY TRAVEL SERVICES

Your enrollment with Optima Health includes a unique emergency travel assistance program for you, your spouse and minor dependent children declared on your health plan provided by Assist America. Coverage is in effect while traveling 100 miles or more away from your permanent residence, or in another country.

Key Services Include:

- Medical Consultation, Evaluation and Referral
- Hospital Admission Assistance
- Medical Repatriation
- Prescription Assistance
- *And more!*

MDLIVE

Get 24/7/365 Access to Board-Certified doctors anytime, anywhere! These doctors are available to diagnose, recommend treatment and prescribe medications when appropriate. Consultations with these doctors are considered in-network, regardless if you use this benefit outside the service area. For more information visit: *www.mdlive.com/optima - or call 1-866-648-3638*

MYOPTIMA PORTAL/MOBILE APP

Through MyOptima you can access ID cards, view coverage and benefit details. You can also find doctors and urgent care centers as well as accessing the other resources listed here!

TREATMENT COST CALCULATOR

- Provides highly accurate geographic-based cost estimates for over 300 procedures and services including x-rays, advanced imaging, outpatient surgeries, office visits, labs, immunizations and inpatient admissions
- Specific estimates based on YOUR plan and YOUR deductible/out-of-pocket maximum exposure
- Helps you and your enrolled family members make more informed decisions, plan for future expenses, compare providers and save money

EMPLOYEE ASSISTANCE PROGRAM

- Life does not always go smoothly. All of us experience times when a personal problem or crisis situation affects the way we function at work or home. Your Employee Assistance Program (EAP) is a problem-solving resource available to you and your household members. A professional counselor will assist you in assessing your situation, finding options, making choices or locating further help.
- *It's free...*Your employer covers the cost of initial assessment, additional problem-solving sessions and referral services. If there is a need for further counseling or treatment, your counselor will help you explore various options.
- *It's confidential...*Your EAP has been set up with Optima Health Insurance Company, an outside counseling resource to assure confidentiality. No one at work will know you have chosen to seek help unless you choose to tell them. Nothing concerning your use of EAP will appear in your personnel file.

The Employee Assistance Program is available to enrolled employees and their household members!
Optima Health Insurance Company is only a phone call away at (800) 899-8174 or visit www.OptimaEAP.com.

HEALTH SAVINGS ACCOUNT

Health Savings Account (HSA)

When you are enrolled in a Qualified High Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone can enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited purpose health care FSA is allowed).

2021/2022 HSA Contributions

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

FOR THE 2021 TAX YEAR:

- $3,600 Individual
- $7,200 Family
- If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.

FOR THE 2022 TAX YEAR:

- $3,650 Individual
- $7,300 Family
- If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense if you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. You can manage your HSA through the optima portal.

Employer Contributions in your the HSA!

NHREC will contribute the following amounts to your HSA:

Employee Only / Employee + Child Medical Tier Enrollment: $800
Employee + Spouse / Employee + Family Medical Tier Enrollment: $1,400

There is also a 50% match for all employee contributions up to the NHREC maximum contribution limit of $1,200 for Employee Only / Employee + Child and $2,200 for all other tiers.

Dental

New Horizons Regional Education Center will continue to offer dental benefits through United Concordia Insurance Company. Please refer to the summary plan description for complete plan details, including out-of-network benefits.

Please Note: It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be so you are not surprised and can budget accordingly. There is also a possibility that suggested procedures may be denied, and alternative procedures approved based upon X-rays and supporting documentation.

	United Concordia Insurance Company Concordia Flex Plan	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$25	$25
Family	$75	$75
Waived for Preventive Care	Yes	Yes
Annual Maximum		
Per Person / Family	$1,500	$1,500
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia		
Benefit Percentage	Not covered	Not covered
Adult (and Covered Full-Time Students, if Eligible)	Not covered	Not covered
Dependent Child(ren)	Not covered	Not covered
Lifetime Maximum	N/A	N/A
Benefit Waiting Periods	N/A	N/A

Vision

Sight, it's a beautiful thing and not to be taken for granted. Whether you want to be incognito and wear contact lenses or stand out in the crowd with the latest stylish frames, this vision plan has you covered. Go anywhere in the network for an exam, but we suggest you use a major retail chain when getting your frames and lenses. New Horizons Regional Education Center provides Vision Insurance though Avesis, Inc.

	Avesis, Inc. Vision 307901442
Copay	
Routine Exams (Annual)	$0 Copay
Vision Materials	
Materials Copay	$0 copay
Lenses	Benefit varies by type of lens. Covered every 12 months.
Contacts Covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level.	Elective contacts covered $130 allowance every 12 months.
Frames	Covered at $50 wholesale allowance, up to $150 retail value every 24 months.

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. Claims that are not work-related 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.

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

Other Benefits

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 11-month employees by the end of July in order 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.

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 $2,750 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 $21.60 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% 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% contribution.

Other Benefits (Continued)

Virginia Retirement System (Continued):

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 any time with MetLife representative, Sung Mi Kim, 757-873-2448, or Valic representative, Tim Hewitt, 757-650-1319.

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.

Other Benefits (Continued)

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, or illness/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.

Other Benefits (Continued)

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.

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. 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.

Monthly Contributions

Employee Contributions (Monthly)	
Optima Vantage 500	
Employee	$50.00
Employee & Spouse	$225.00
Employee & Child	$185.00
Employee & Family	$325.00

Employee Contributions (Monthly)	
Optima Equity Vantage 3000	
Employee	$15.00
Employee & Spouse	$114.00
Employee & Child	$80.00
Employee & Family	$183.00

Employee Contributions (Monthly)	
Optima POS 500	
Employee	$126.00
Employee & Spouse	$426.00
Employee & Child	$303.00
Employee & Family	$567.00

Employee Contributions (Monthly)	
United Concordia Flex Plan	
Employee	$0.00
Employee & Spouse	$27.30
Employee & Child	$13.86
Employee & Children	$30.00
Employee & Family	$59.56

Employee Contributions (Monthly)	
Avesis Vision	
Employee	$10.79
Employee & Spouse	$18.88
Employee & Child(ren)	$19.94
Employee & Family	$27.98

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.

New Horizons
REGIONAL EDUCATION CENTERS

Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 11 for more details.

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***IMPORTANT NOTICE**: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*

Important Legal Notices Affecting Your Health Plan Coverage

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

f 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 or 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.

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 $156 per day (up to a $1,566 cap per request), 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:

Nikia Belizaire
Hampton, VA
United States 23666
757-766-1100
nikia.belizaire@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

Questions regarding any of this information can be directed to:

Nikia Belizaire

Hampton, VA

United States 23666

757-766-1100

nikia.belizaire@nhrec.org

10/01/2022

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

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 Important Notice from 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 Center has determined that the prescription drug coverage offered by the HMO Vantage 500/20/20% plan, the HMO Equity Vantage 300/0% plan, and the POS 500/20/20% plan are, 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 [Insert Name of Entity] 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 information. **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:	10/01/2022
Name of Entity/Sender:	Nikia Belizaire
Contact--Position/Office:	Benefits/Payroll Specialist
Address:	520 Butler Farm Road Hampton, VA - 23666
Phone Number:	757-766-1100

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

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – 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: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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)	**MONTANA – 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: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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

MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – 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: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**

Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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, 2021, 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 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

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.

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 Education Centers	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: 233666
10. Who can we contact about employee health coverage at this job? Nikia Belizaire		
11. Phone number (if different from above) 757-766-1100	12. Email address nikia.belizaire@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)