New Horizons
REGIONAL EDUCATION CENTERS

Benefits Guidebook

Plan Year | 2016 – 2017

Guidebook Contents

ABOUT THIS BENEFITS GUIDEBOOK

This overview describes the highlights of our health insurance program. **Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this Benefits Guidebook.**

If there is any discrepancy between descriptions of the programs as contained in these materials and the official plan documents, the language of the official plan documents shall prevail. Please refer to your certificate of coverage published by each of the respective carriers for detailed plan information. To obtain a certificate of coverage, contact the Human Resources Department.

Any of these benefits may be modified or terminated at any time to meet Internal Revenue Service rules or otherwise as determined by NHREC.

Welcome

Making a Difference

New Horizons Regional Education Centers (NHREC) is proud to provide our employees with comprehensive medical coverage. You can choose a plan that is best for you and your family. This reflects our commitment to making a difference and protecting our most valuable asset, our employees.

This benefits guidebook is designed to serve as an overview of the benefit options available to you, as an employee of NHREC. In addition, it includes important legal and compliance notifications.

This Guidebook will help familiarize you with the NHREC health insurance program. Carefully consider each option, its value to you and whether it meets your particular needs.

Annual Open Enrollment – Benefit elections must be submitted within the required timeframe each year (contact Human Resources for specific annual open enrollment dates).

Newly eligible employees or employees who experience a Qualifying Life Event (QLE) – Please make sure that you submit your elections within 30 days of your benefits effective date or the date you experienced a QLE. Contact Human Resources if you have questions about this deadline or Qualifying Life Events.

Overview and Eligibility

Benefit Plan Year

The NHREC medical plan year begins on October 1st and ends the following September 30th. This Guidebook outlines the benefits that apply to the plan year.

Who is Eligible?

All full-time employees are eligible to participate in the Plan. Health insurance or dental coverage will begin the first of the month following your date of hire. Applications for such coverage must be completed within 30 days of employment.

Dependent Coverage Rules

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 I Participate?

Benefits begin the first of the month following your date of hire, provided you are actively at work on the date you become eligible.

There are also certain Qualifying Life Events, which may allow you to participate in our plans after your initial eligibility. Please refer to the Qualifying Life Events section for more information.

Benefits Overview

Medical

We will continue to offer medical benefits through Anthem BlueCross BlueShield. We will continue to offer an HMO with out of network benefits, a PPO and a High Deductible Health Plan with an HSA.

NHREC 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-	2016 - $3,350 **2017 - $3,400**
The maximum allowable Family contribution into the HSA-	2016 - $6,750 **2017 - $6,750**

Dental

Our dental insurance will remain with United Concordia. We have added new benefits for prevention, pregnancy and wellness. Make sure you read your United Concordia benefit summary.

We will continue to offer the following benefits with no changes:

- Voluntary Vision through Avesis
- Flexible Spending Accounts through Flexible Benefit Administrators
    - Healthcare flexible spending
    - Dependent care flexible spending

The Affordable Care Act

The individual mandate penalty for not having minimum essential coverage is currently $695 per individual or 2.5% of household income, however it may increase in 2017. If you do not qualify for coverage through New Horizons, you will have to obtain coverage though another option, such as a health insurance marketplace, your spouse's plan, or other federal programs such as Medicare, Medicaid or TRICARE, or pay the penalty.

Network Information

A network is an insurance company's group or list of approved or contracted providers from which you can obtain service at the plan's highest benefit level.

We recognize how crucial good medical care is for your well-being and the well-being of your family. NHREC provides its' employees with comprehensive HMO and PPO plans through Anthem BlueCross BlueShield. All medical contributions are deducted on a pre-tax basis when available.

Anthem HMO / POS Plans

The HMO/POS plans are available to Virginia residents only. Anthem BCBS HMO/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.

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**

Medical Benefit Overview

Carrier / Benefit	Anthem HK Value Advantage 20/20 POS Open Access	Anthem KeyCare 25 PPO	Anthem HK HSA 573 3000/100% POS
In Network			
In-Network Calendar Year Deductible:	$0 / $0	$500 / $1,000	$3,000 / $6,000
In-Network Out of Pocket Maximum (OOP): Individual/Family	$4,000 / $8,000	$4,000 / $8,000	$4,000 / $8,000
Embedded / Non-Embedded	Embedded	Embedded	Embedded
In-Network Coinsurance	20%	20%	0%
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Office Visits			
Primary Care Physician	$20	$25	0% after deductible
Specialist	$40	$50	0% after deductible
Referral Necessary	*No*	*No*	*No*
Preventive Care			
Well-Child Care / Immunizations	covered at 100%	covered at 100%	covered at 100%
Adult Periodic Wellness Exams	covered at 100%	covered at 100%	covered at 100%
Routine Annual Gynecological Exam	covered at 100%	covered at 100%	covered at 100%
Mammograms	covered at 100%	covered at 100%	covered at 100%
Vision Exam	$15 every 12 months	$15 every 12 months	$15 every 12 months
Hospitalization			
Inpatient	20%	20% after deductible	0% after deductible
Outpatient (Surgery)	20%	20% after deductible	0% after deductible
Other Services			
Emergency Room (waived if admitted)	20%	20% after deductible	0% after deductible
Urgent Care	$20 / $40	$25 / $50	0% after deductible
Diagnostics, Labs, X-rays	20%	20% after deductible	0% after deductible
Advanced Imaging (MRI, CT Scans)	20%	20% after deductible	0% after deductible
Prescription Drugs	**$150 Rx Deductible**	**$150 Rx Deductible**	**After Plan Deductible**
Retail, Tier 1	$10	$10	$10
Retail, Tier 2	$30	$30	$30
Retail, Tier 3	$50	$50	$50
Retail, Tier 4	20%	20%	20%
Non-Network			
Out-of-Network Calendar Year Deductible:	$750 / $1,500	$1,250 / $2,500	$3,000 / $6,000
Out-of-Network Out of Pocket Maximum (OOP):	30%	$5,500 / $11,000	$6,000 / $12,000
Out-of-Network Coinsurance	$5,000 / $10,000	40%	20%
Lifetime Maximum	Unlimited	Unlimited	Unlimited

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.

LiveHealth Online is available to handle many non-urgent matters such as: cold and flu symptoms; allergies; sinus infections; bronchitis. Anthem members will pay their PCP copay at the time of the call.

To take advantage of the benefit, you will need access to a webcam or another similar video streaming such as: Facetime or Skype.

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

Dental Benefits Overview

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 towards 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.

Vision Benefits Overview

YOUR AVESIS VISION PLAN

New Horizons Reginal Education Ctr.

Your vision health is an important part of complete wellness. Avesis is pleased to present your vision benefits which are designed to give you and your covered family members the care, value and service to help maintain good vision and overall health.

Valuable Savings on Crizal Lenses
Ask your vision care provider about the premium No-Glare lens
Crizal
Live Life In the Clear™

In-Network Benefits

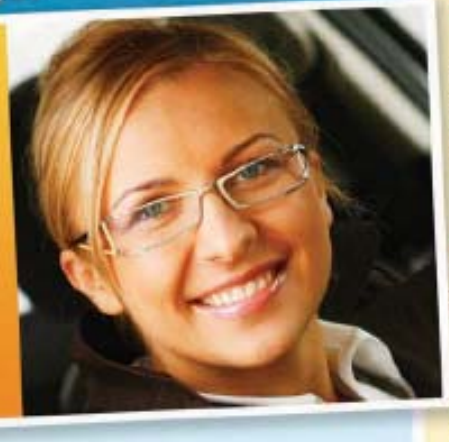
Vision Examination — **Your vision exam is covered in full after a co-pay.**

$200* average retail — When choosing the **frames** and **spectacle lenses** package!

FRAMES
Providers typically charge between $100 - $150* for frames covered in full by your plan allowance.

AND

SPECTACLE LENSES
Standard lenses are covered in full. Providers typically charge between $60 - $120* for standard lenses.



Contact Lenses — In lieu of frames and spectacle lenses, members receive an allowance up to $130 for materials and fit and follow-up exam
Medically necessary contact lenses are covered in full (prior authorization is required)

LASIK Surgery — Members receive a one-time/lifetime allowance of $150

Additional Discounts

Progressive Lenses
Are discounted up to 20% off retail in addition to a $50 allowance

Specialty Lenses
Are discounted up to 20% off retail in addition to the corresponding standard lens allowance

Lens Options, Non-Covered Items and Additional Purchases
Are discounted up to 20% off retail

LASIK Surgery
5% - 25% off retail

* Values provided may be more or less depending on the provider's retail pricing.

** Provider wholesale frame pricing for your plan is $50. Participating Wal-Mart locations cover frames up to a $68 retail value, additional discounts on lenses and options do not apply.

Avēsis
A National Vision, Dental and Hearing Company

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

Group Details

Effective Date:	**10/01/2016**
Group Number:	30790-1442
Plan #:	914

Benefit Frequency

	Every:
Vision Exam	12 Months
Spectacle Lenses	12 Months
Frames	24 Months
Contact Lenses	12 Months

Co-Pays

Vision Examination	$0.00
Materials	$0.00

Rates

Employee Paid Rates Per Month

Employee Only	**$10.79**
Employee + Spouse	**$18.88**
Employee + Child(ren)	**$19.94**
Employee + Family	**$27.98**

Out-of-Network Reimbursement

	Up to:
Exam	$35.00
Standard Single Vision	$25.00
Standard Bifocal	$40.00
Standard Trifocal	$50.00
Standard Lenticular	$60.00
Progressive	$40.00
Specialty Lenses	Corresponding Standard Lens Reimbursement
Frame	$45.00
Contact Lenses (Elective)	$130.00
Contact Lenses (Med. Necessary)	$250.00
LASIK Surgery	$150.00

www.avesis.com

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.)

Qualifying Life Events

Changing Your Benefits – Qualifying Life Events (QLEs)

REPORTING QUALIFYING LIFE EVENTS (QLE)

QLEs, also referred to as life event changes, allow you to make benefit changes during the year in which they occur. For any allowable changes, you must submit a benefit change request to the Human Resources Department within 30 days of the event.

(60 days for CHIP)

The Internal Revenue Service (IRS) states eligible employees may only make pre-tax elections to the plan once per year at open enrollment. Open enrollment benefit elections are binding through September 30th of each plan year.

Below are some examples of the most common Qualifying Life Events. These events generally allow you to make changes to your benefit plans, such as cancelling your coverage, adding or terminating dependent coverage, and modifying your plan selections. The allowable plan changes must be consistent with the event and will be governed by our insurance carriers, the IRS, and our Plan Documents.

You must notify the Human Resources Department of any life event changes 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.

- ✓ **Birth or adoption**
- ✓ **Change in residence**
- ✓ **Court ordered dependent coverage**
- ✓ **Death of dependent**
- ✓ **Dependent loss of eligibility**
- ✓ **Divorce**
- ✓ **Marriage**
- ✓ **Loss of other health coverage**
- ✓ **Spouse change of employment**
- ✓ **You change employment**

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 year. 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 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.

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

Other Benefits

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 "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 (Five Hundred Fifty Dollars) for one successfully completed class per year based on the actual cost of the class. The Center may pay up to $1,000 (One Thousand Dollars) 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 end of January. 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

Other Benefits

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.

Other Benefits

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 no 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 $5000.00.

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

Important Laws and Notices

Newborn & Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (i.e. your physician, nurse midwife or physician's assistant) after consultation with the mother, discharges the mother or newborn earlier.

Plans and issuers may not select the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

Women's Health & Cancer Rights Act

On October 21, 1988, the Women's Health and Cancer Rights Act became effective. This law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies.

As the Act requires, we have included this notification to inform you about the law's provisions. The law mandates that a plan participant receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Mental Health Parity Act of 1996 (MHPA)

The MHPA requires the Company to satisfy new minimum standards regarding mental health benefits. The new standards require parity between mental health benefits and other health benefits with respect to lifetime and annual dollar limits. Thus, the health plan offers coverage for both medical/surgical benefits and mental health benefits, but cannot impose different lifetime or annual dollar limits on the two classes of benefits the plan can reimburse.

Important Laws and Notices

Special Enrollment Rights

HIPAA requires that you be informed of your Special Enrollment rights when you and/or your eligible dependents decline health care coverage during the initial enrollment period.

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in the medical plan provided that you request coverage within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or a court order, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption or the court order.

If you are declining health coverage for yourself or your dependents (including your spouse) and you are not currently covered under a medical plan, you will be considered a late applicant.

HIPAA allows a late applicant to enter a medical plan only during an open enrollment period.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA law requires employers to offer continuation of coverage for certain benefits offered under the Plan. COBRA continuation is only available to Covered Employees and their qualified dependents (any person who, as of the day of a Qualifying Event is a Participant covered under the Plan).

To learn more about your rights under COBRA and details regarding qualifying events, qualified beneficiaries, election periods, and duration of coverage, please see Human Resources to obtain a copy of the Initial COBRA Notice or the Summary Plan Description.

Important Laws and Notices

Important Notice from NHREC 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 your employer 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 and 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

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. **Your employer has determined that the prescription drug coverage offered by the Employee Welfare Program 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 15th through 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 employer coverage will not be affected and you can still maintain your current benefits under the employer plan.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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 your employer 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 your employer 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).

Important Laws and Notices

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

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 July 31, 2013. You should contact your State for further information on eligibility

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

For more information on special enrollment rights, you can contact either:

U.S. Department of Health and Human Services Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

U.S. Department of Labor
www.dol.gov/ebsa
1-866-444-EBSA (3272)

OMB Control Number 1210-0137 (expires 10/31/2016)

This overview describes the highlights of our Benefits Program. **Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this Benefits Guidebook.**

If there is any discrepancy between descriptions of the programs as contained in these materials and the official plan documents, the language of the official plan documents shall prevail. Please refer to your certificate of coverage published by each of the respective carriers for detailed plan information. To obtain a certificate of coverage, contact the Human Resources Department.

2016 Employee Contributions

Medical

Healthkeepers 20/20 POS	Total Premium	NHREC	Employee
Employee	$762.97	$712.97	$50.00
Employee/child	$1,220.75	$1,085.75	$135.00
Employee/spouse	$1,602.29	$1,427.29	$175.00
Family	$2,365.28	$2,115.28	$250.00

Keycare	Total Premium	NHREC	Employee
Employee	$831.77	$705.77	$126.00
Employee/child	$1,330.82	$1,027.82	$303.00
Employee/spouse	$1,746.72	$1,320.72	$426.00
Family	$2,578.53	$2,011.53	$567.00

Healthkeepers HDHP (HSA)	Total Premium	NHREC	Employee
Employee	$597.22	$582.22	$15.00
Employee/child	$955.54	$925.54	$30.00
Employee/spouse	$1,254.17	$1,190.17	$64.00
Family	$1,851.38	$1,743.38	$108.00

Dental

United Concordia Dental Plan	Total Cost	NHREC Cost	Employee
Employee	$34.56	$34.56	$0.00
Employee/Child	$50.97	$37.11	$13.86
Employee/Children	$70.09	$40.09	$30.00
Employee/Spouse	$66.90	$39.60	$27.30
Employee/Family	$105.10	$45.54	$59.56

Vision

Avesis Vision Plan	Total Cost	NHREC Cost	Employee
Employee	$10.79	$0.00	$10.79
Employee/Child(ren)	$19.94	$0.00	$19.94
Employee/Spouse	$18.88	$0.00	$18.88
Employee/Family	$27.98	$0.00	$27.98