

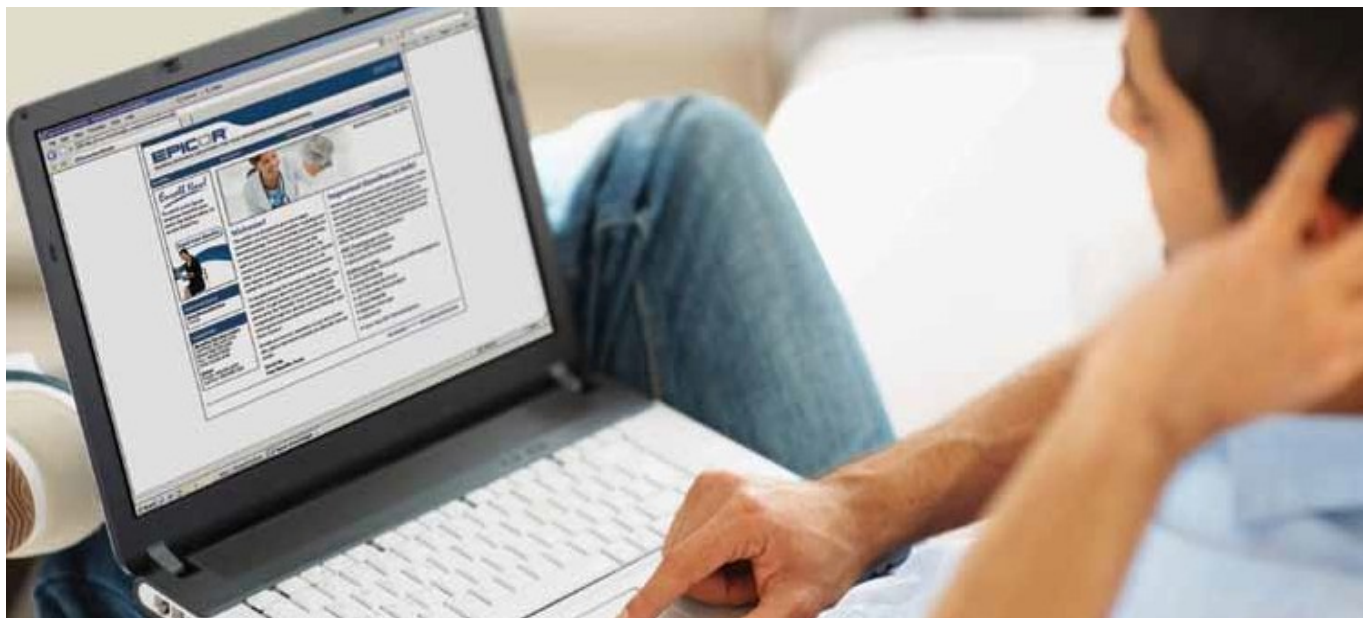


**Hourly Employees
Benefit Enrollment Guide
2016-2017**

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Sources of Assistance				
Policy	Carrier Name	Group Number	Telephone	Website
Medical Plans				
All Eligible Employees	Providence Health Plans	100377	800-562-8964	www.providence.org
Dental Plan				
Dual-Option Dental	Willamette Dental Group	Z626	503-644-6545	www.willamettedental.com
	PacificSource	12333	800-624-6052	www.pacificsource.com
Additional Lines of Coverage				
Life and AD&D Insurance	Lincoln Financial	10181096	800-423-2765	www.lfg.com
Short Term Disability (STD)	Lincoln Financial	10181096		
Benefit Resource Center (BRC)	USI Insurance Services	N/A	1-866-4ourBRC	4ourBRC@usi.com





Eligibility & Enrollment

Eligibility Rules

Full-time equivalent employees regularly working at least 20 hours per week are eligible to participate in the Head Start Employee Benefits Program. For most benefit plans your coverage will become effective on the first of the month following 60 days from your date of hire. You must be actively at work for your coverage to be effective on your eligibility date. You may also enroll your eligible dependents in the Head Start Benefit Plans. Your eligible dependents include your legal spouse/registered partner or qualified domestic partner as well as your eligible dependent children, whether natural, adopted, stepchildren, foster, or those for whom you have legal custody by court decree. When enrolling in medical, dental or vision coverage, you may enroll any eligible child up to age 26 regardless of place of residence, marital status or financial dependence on you.

Enrollment Is Simple

Open Enrollment is a once-a-year opportunity to make changes to your current benefits and to review which dependents you be will covering during the new plan year. All changes you request will take effect October 1st.

If no changes are made, your previous elections will continue for the 2016 - 2017 plan year.

When Can You Enroll?

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

- After completing your initial eligibility period
- During the annual open enrollment period
- Within 60 days of a qualified family-status change
- If you do not enroll at the above times, you must wait for the next annual open enrollment period.

Making Changes

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify your Benefits Administrator within thirty (30) days of the event.

Examples of change in status events may include:

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

If you have a family status change, you must timely notify your Benefits Administrator and complete the necessary forms. Employees have up to 30 days to report any status changes that may affect their benefits enrollment. For more information contact your Benefits Administrator.



2016 Benefits at a Glance

Medical Insurance

The plan with Providence offers employees working at least 20 hours per week specific preventive care at no cost to you, \$15 Copays for professional services and 30% coinsurance for hospital or surgery services after you have paid the \$1,000 deductible. Head Start contributes premium funds to help cover the cost for employees to enjoy this coverage. Employees can also elect to have their eligible children on the medical plan at an additional cost.

Dental Insurance

Head Start offers employees working at least 20 hours per week a dental plan with rich benefits through PacificSource and the ability to choose any provider. The plan has a \$50 single / \$150 family deductible that must be met prior to the plan paying on services. All eligible employees and their dependents can be enrolled on this plan. Another comprehensive option offered is the Willamette Dental plan which unlike the PacificSource plan, has a \$0 deductible and no annual maximum. The copay amount varies depending on the type of service. However, with this plan you may only visit Willamette Dental providers in order to receive the benefit. For a complete list of all covered services, you can visit your employee handbook.

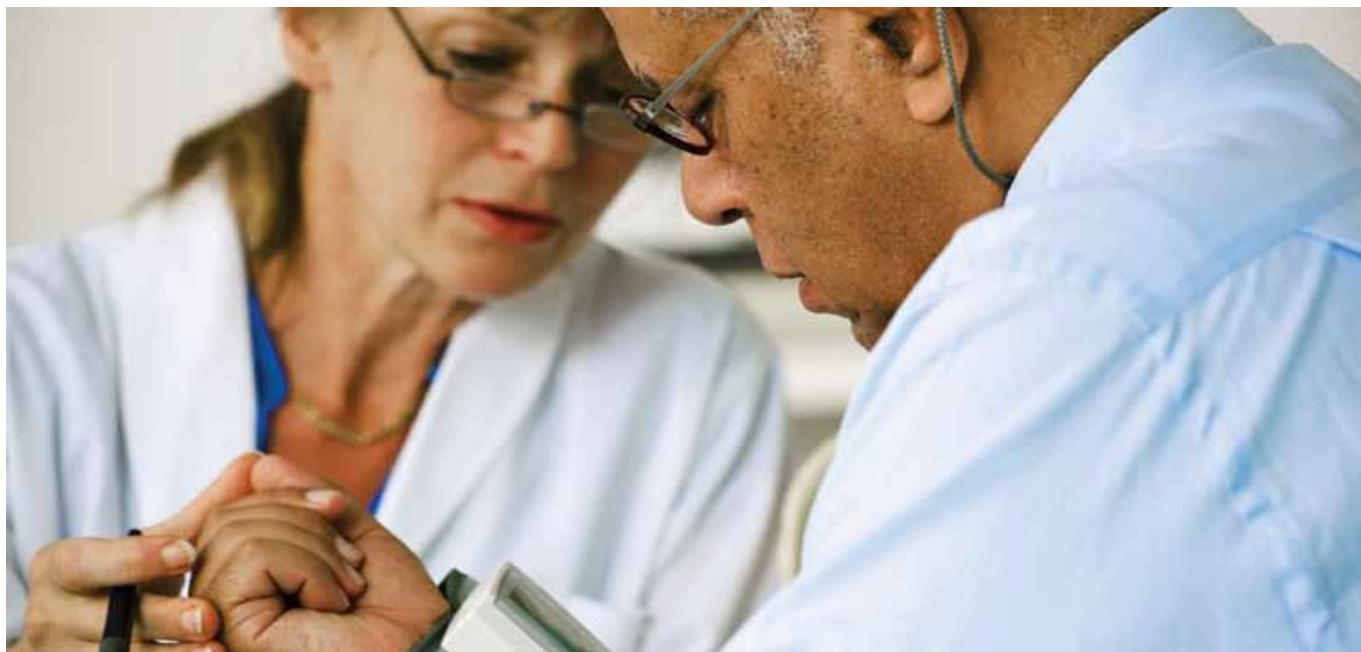
Life and AD&D Insurance

Employer-Paid Life

Head Start provides eligible full-time employees with basic life and AD&D insurance in the amount through Lincoln Financial at no cost to you. The amount of benefit that you receive depends on your employee status.

Short Term Disability (STD)

Head Start offers an employer paid Short Term Disability (STD) benefit through Lincoln Financial for non-work-related injury or illness. This STD plan pays a varying percentage of your weekly base pay, after a waiting period of 15 consecutive days of disability, injury or sickness. Benefits may continue up to a maximum of 11 or 13 weeks, depending on your employee status..



Cost of Coverage: *How You Pay for Health Care Costs*

You share the cost of health care services with Head Start and the medical plan you select. As you review the medical plan options you should consider the following types of costs:

Premium*: A premium is the total cost for your medical insurance. You and Head Start share this cost. You pay your portion through pre-tax payroll deductions.

Copay: A copay is a set payment you make for a specific service. For example, in the Providence medical plan you will make a \$15 copay for visits to your primary care physician.

Deductible: A deductible is the amount you must pay before the medical plan begins sharing the cost of services. You pay this full amount, if required by your plan, before the plan pays benefits.

Coinsurance: When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan. For example, in the Providence health plan, after you satisfy your deductible, you will pay 30% for most medical care that you receive from preferred providers. Coinsurance may vary depending on the service received.

Out-of-Pocket Maximum: The annual out-of-pocket maximum protects you from major medical expenses. This is the most you would pay and includes your medical deductible, copays and coinsurance, for eligible expenses during a plan year unless otherwise stated. Once you reach the out-of-pocket maximum, the plan pays 100% of the usual, customary and reasonable (UCR) charges for eligible services for the balance of the calendar year.

Your Total Costs

Remember, the total cost you pay for health care services in a plan year is the combination of your out-of-pocket costs when you access medical care and the premium payments you are required to make for coverage.

***Premiums are not applied towards your deductible or out-of-pocket maximums.**

Premiums + Out-of-Pocket Costs = Total Cost of Health Care

Your Benefit Summary

Personal Option Plan

Head Start of Lane County



Copay	What You Pay	Calendar Year Out-of-Pocket Maximum	Calendar Year Deductible
\$15	30% coinsurance (after deductible)	\$3,500 per person \$7,000 per family (2 or more)	\$1,000 per person \$2,000 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- Your deductible is included in the out-of-pocket maximum amount listed above.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- View a list of Providence Signature network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Personal Option Plan Benefit Highlights		After you pay your calendar year deductible, then you pay the following for covered services
✓ No deductible needs to be met prior to receiving this service		Copay or Coinsurance (from in-network providers only)
Preventive Care		
<ul style="list-style-type: none"> • Periodic health exams and well-baby care • Routine immunizations and shots • Colonoscopy (age 50 +) • Gynecological exams (calendar year) and Pap tests • Mammograms • Tobacco cessation, counseling/classes and deterrent medications 		Covered in full✓ Covered in full✓ Covered in full✓ Covered in full✓ Covered in full✓ Covered in full✓
Physician / Provider Services		
<ul style="list-style-type: none"> • Office visits • Office visits to alternative care providers (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.) • Phone and video visits (including Providence Health eXpress®) • Allergy shots, serums, infusions, and injectable medications • Inpatient hospital visits • Surgery; anesthesia 		\$15 / visit✓ \$15 / visit✓ \$5 / visit✓ 30% 30% 30%
Diagnostic Services		
<ul style="list-style-type: none"> • X-ray and lab services • High-tech imaging services (such as PET, CT or MRI) • Sleep studies 		30%✓ 30%✓ 30%✓
Emergency and Urgent Services		
<ul style="list-style-type: none"> • Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.) • Urgent care services (for non-life threatening illness/minor injury) • Emergency medical transportation (air and/or ground) 		\$250✓ \$15 / visit✓ 30%
Hospital Services		
<ul style="list-style-type: none"> • Inpatient/Observation care • Rehabilitative care (limited to 30 days per calendar year) • Skilled nursing facility (limited to 60 days per calendar year) 		30% 30% 30%
Outpatient Services		
<ul style="list-style-type: none"> • Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy • Colonoscopy (non-preventive) • Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime) • Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year) 		30% 30% 50% \$25 / visit✓

Personal Option Plan Benefit Highlights (continued)		Copay or Coinsurance
Maternity Services		
<ul style="list-style-type: none"> • Prenatal office visits • Delivery and postnatal services • Inpatient hospital/facility services • Routine newborn nursery care 		Covered in full✓ \$150 / delivery✓ 30% 30%✓
Medical Equipment, Supplies and Devices		
<ul style="list-style-type: none"> • Medical equipment, appliances and supplies • Diabetes supplies (lancets, test strips and needles) • Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived) 		30% 30%✓ 30%
Mental Health / Chemical Dependency		
(To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
<ul style="list-style-type: none"> • Inpatient and residential services • Day treatment, intensive outpatient, and partial hospitalization services • Applied behavior analysis • Outpatient provider office visits 		30% 30% 30% \$15 / visit✓
Home Health and Hospice		
<ul style="list-style-type: none"> • Home health care • Hospice care 		30% Covered in full✓

Your guide to the words or phrases used to explain your benefits

Coinsurance

The percentage of the cost that you may need to pay for a covered service.

Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Deductible

The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan.
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan.
- Penalties incurred if you do not follow your plan's prior authorization requirements.
- Copays and coinsurance for services that do not apply to the deductible.

Formulary

A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

In-Network

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Limitations and Exclusions

All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Out-of-Pocket Maximum

The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

Personal physician/provider

A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization

Some services must be pre-approved, your in-network provider will request prior authorization for these services.

Usual, Customary & Reasonable (UCR)

Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Contact us

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.



Portland Metro Area: **503-574-7500**
 All other areas: **800-878-4445**
 TTY: **711**



Have questions about your benefits and want to contact us via email? Go to our website at:
www.ProvidenceHealthPlan.com/contactus

Prescription Drugs

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at www.myProvidence.com.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to over 26,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

Drug Coverage Category	Copay or Coinsurance		
	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Preventive drug	Covered in full	Covered in full	Does not apply
Preferred generic drug	\$15	\$30	Specialty drugs 50% up to \$100
Generic drug	\$20	\$40	
Preferred brand-name drug	\$45	\$90	
Brand-name and compounded drugs (compounded drugs are limited to a 30-day supply)	50% up to \$100	50% up to \$200	

Alternative Care

Your Benefit Summary

Chiropractic Manipulation and Acupuncture



Copay	Maximum Calendar Year Benefit
\$25	\$500 per member

Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at www.myProvidence.com.

- With this benefit you have access to in-network qualified practitioners, including chiropractors and acupuncturists, for chiropractic manipulations and acupuncture

Medical / Rx / Alternative Care Benefit	Your Cost (Monthly)
Employee Only	
Employee + Child(ren)	

Dental Insurance

Head Start offers a Dual-Option Dental plan through PacificSource and Willamette Dental for all eligible employees. In order to understand the plan benefits and employee responsibilities, please refer to the benefit summaries on the following pages.

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.*

PacificSource Plan

This plan provides dental coverage with a \$50 per member deductible for single enrollment and a \$150 family deductible. Therefore, if you or your dependent(s) has any of the listed services done at a participating provider, you will only have to pay the deductible, then the coinsurance cost for that service. The coinsurance benefit amount on the following pages is the amount that is paid for by the plan. The annual benefit limit (\$2,000) is the maximum amount the plan will pay for any of your services, including the cost of preventive care. This limit is based on per person enrolled on the plan.

Willamette Dental Plan

The plan offered through the Willamette Dental network is a copay-based plan, meaning that you will only be responsible for a copayment (\$15 for most services) when receiving services from Willamette Dental In-Network providers. While you can choose any provider through the PacificSource plan, you can only see Willamette Dental providers when enrolling in this plan. If you use a doctor that is not in the network, you will have no coverage for services provided to you. By comparing the PacificSource and Willamette Dental plans you can choose the one that fits best for you and your dependents.



Dental Benefit	Your Cost (Monthly)
Employee Only	
Employee + Spouse	
Employee + Family	
Employee + Child(ren)	

The following services may also be provided by a dental hygienist or denturist to the extent that they are operating within the scope of their license as required under law in the state of issuance. Eligible charges are limited to the usual, customary, and reasonable charges of dental providers in the same service area for similar treatment of similar dental conditions.

Advantage Network dentists agree to write off any charges over and above negotiated, contracted fees for most services. When you use an Advantage Network dentist, you will not be responsible for any excess charges and will pay only your plan's coinsurance amount.

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
All Providers	\$50	\$150
Annual Benefit Maximum		
\$2,000 per person per calendar year. Applies to all covered services.		

The member is responsible for the above deductible and the following co-insurance.

Service	All Providers
Class I Services	
Examinations	No charge*
Bitewing films, full mouth x-rays and/or panorex	No charge*
Dental cleaning (Prophylaxis and periodontal maintenance)	No charge*
Topical fluoride	No charge*
Fluoride varnish	No charge*
Sealants	No charge*
Space maintainers	No charge*
Athletic mouth guards	No charge*
Brush biopsies	No charge*
Class II Services – Restorative Treatment	
Fillings	20% co-insurance
Simple surgical extractions	20% co-insurance
Periodontal scaling	20% co-insurance
Root planning and/or curettage	20% co-insurance
Full mouth debridement	20% co-insurance
Class II Services – Complicated Treatment	
Complicated oral surgery	20% co-insurance
Pulp capping	20% co-insurance
Pulpotomy	20% co-insurance
Root canal therapy	20% co-insurance
Periodontal surgery	20% co-insurance
Tooth desensitization	20% co-insurance
Class III Services	
Crowns	50% co-insurance
Replacement of existing prosthetic device	50% co-insurance
Dentures	50% co-insurance
Bridges	50% co-insurance
Implants	50% co-insurance

This is a brief summary of benefits. Refer to your handbook for additional information or a further explanation of benefits, limitations, and exclusions.

* Not subject to annual deductible.

Summary of Benefits

Group Number: OR56 Effective
Date: October 1, 2016



Head Start of Lane County

BENEFITS	COPAYS
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General & Orthodontic Office Visit	You pay a \$15 Copay per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings (Amalgam)	Covered with the Office Visit Copay
Porcelain-Metal Crown	You pay a \$300 Copay
PROSTHODONTICS	
Complete Upper or Lower Denture	You pay a \$350 Copay
Bridge (per Tooth)	You pay a \$300 Copay
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	You pay a \$100 Copay
Root Canal Therapy – Bicuspid	You pay a \$135 Copay
Root Canal Therapy – Molar	You pay a \$170 Copay
Osseous Surgery (per Quadrant)	You pay a \$150 Copay
Root Planing (per Quadrant)	You pay a \$40 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	You pay a \$80 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a \$150 Copay*
Comprehensive Orthodontia Treatment	You pay a \$2,800 Copay
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a \$40 Copay
Specialty Office Visit	You pay a \$30 Copay per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of \$100

*Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental Insurance, Inc.

This plan provides extensive coverage of services and supplies to prevent, diagnose, and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

Life / AD&D Insurance

Company Paid Basic Life and Accidental Death & Dismemberment (AD&D)

Although we don't like to think about it, should death occur, the survivors left behind could face serious financial hardships. Your family might need an alternative source of income to pay off your bills and meet their ongoing financial responsibilities. That is the purpose of life insurance—to provide funds for those left behind.

It is also possible that an accident could cause serious injury—the loss of limbs or eyesight, for example. There is special insurance coverage which pays benefits if an accident causes the loss of life, limb or sight—it is called accidental death and dismemberment (AD&D) insurance. AD&D pays an amount equal to your life insurance benefit in the event of your accidental death. It also provides benefits for certain accidental injuries. Head Start offers all full-time, regular employees a company paid basic life and AD&D benefit through Lincoln Financial at no cost to you. You will receive the following benefit amount:

Flat \$20,000 of Benefit

Benefit Reduction	Employee
Benefits will reduce:	35% at age 65 An additional 15% of the original amount at age 70 Benefits terminate at retirement
Additional Benefits	Employee
See Understanding Your Benefits Page:	Accelerated Death Benefit Seat Belt, Airbag, and Common Carrier Conversion Accident Plus
Enrolling for Coverage	Employee
Eligibility:	All employees in an eligible class.

Understanding Your Benefits	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to be paid a portion of your life insurance benefit when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you must be covered under this policy for the amount of time defined by the policy.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (e.g., the loss of a hand, foot, or eye), subject to policy limitations.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election normally must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without providing Evidence of Insurability. Evidence of Insurability will be required for any amounts above this, for late enrollees or increases in insurance, and it will be provided at your own expense.
Seat Belt, Airbag, and Common Carrier	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to \$10,000 or 10% of the principal sum, whichever is less. If loss occurs due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.

Disability Insurance

Short Term Disability Insurance

The Short Term Disability (STD) plan is administered by Lincoln Financial and provides you with disability income benefits for short-term disabilities resulting from non-work-related injury, illness or pregnancy. Highlights of the Short Term Disability plan include:

- Benefits begin on the 15th day after an accident or illness
- STD benefits cease once the LTD benefits begin
- Benefit percentage of 60% up to \$500
- Benefit duration of 13 Weeks



Important Legal Notices Affecting Your Health Plan Coverage

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/registered partner or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

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

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

Enforce your Rights

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

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

Assistance with your Questions

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

MARKETPLACE EXCHANGE NOTICE

About the Enclosed Marketplace Exchange Notice:

The following notice describes the new online Health Insurance Marketplace (also called an Exchange) available at www.healthcare.gov. The Marketplace describes options you may have available for health insurance (other than employer-based plans), and is designed for easy cost and coverage comparisons. The enclosed notice also includes information about coverage you may be eligible for through Head Start.

Effective January 1, 2014, all employees were required to have medical coverage or you will have to pay a penalty (in the form of a tax). If you do not qualify for coverage through Head Start or you do not enroll yourself or a dependent, you will have to obtain coverage elsewhere or pay the penalty. This penalty is known as the 'individual mandate penalty'.

What do I do next?

Review the information provided in the notice. You can learn more about the Marketplace at www.healthcare.gov.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: 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.

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.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, 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 pre-tax and 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 your administrator.

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.

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.

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. (Numbers correspond to the Marketplace application)

3. Employer name: *Head Start of Lane County*
4. Employer Identification Number: **93-0728229**
5. Employer address: **221 B Street**
6. Employer phone number: **541-747-2425**
7. City: **Springfield**
8. State: **Oregon**
9. ZIP code: **97477**
10. Who can we contact about employee health coverage at this job? **Sally Pope**
11. Phone number (if different from above)
12. Email address:

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

•As your employer, we offer a health plan to:

All eligible employees. Eligible employees are: considered to regularly work at least 20 hours per week.

•With respect to eligible dependents:

We do offer coverage. Eligible dependents are: your legal spouse/registered partner and your eligible child(ren) to age 26, including a child that is adopted, fostered, etc.

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.**

MEDICARE part d NOTICE

Important Notice from Head Start

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

When Can You Join A Medicare Drug Plan?

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

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

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 Head Start coverage will not be affected. You can keep this coverage if you elect Part D.

If you do decide to join a Medicare drug plan and drop your current Head Start coverage, be aware that you and your dependents will only be able to get this coverage back by satisfying the plan's eligibility criteria.

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 Head Start 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 Head Start changes. You also may request a copy of this notice at any time.

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).

Note: Please provide a copy of this Notice to your Medicare-eligible dependents who have coverage under this plan.

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: August 1, 2016
Name of Sender: Head Start of Lane County
Contact: Sally Pope
Address: **221 B Street Springfield, OR 97477**
Phone Number: 541-747-2425

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).

Questions regarding any of these rights can be directed to:

Sally Pope
221 B Street
Springfield, OR 97477

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.mns.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 6165



Summary provided by the Broker of Record for
Head Start of Lane County:

USI Insurance Services
975 Oak Street, Ste 900
Eugene, OR 97401
541-685-5300

Please note: The broker for Head Start of Lane County, USI, offers the Benefit Resource Center to ensure your health and welfare plan is operating efficiently. It is designed to provide a responsive, consistent, hands-on approach to your benefit inquiries. Benefit Specialists are available to research and solve issues from Monday through Friday, 8:00 am to 5:00 pm, at 1-866-4ourbrc or 4ourbrc@usi.com.

