District Council 1707, Local 95
Head Start Employees Welfare Fund

Dear Plan Participant,

Each year you have the opportunity to review your current health insurance benefits and make changes to these benefits for the upcoming plan year. This year's open enrollment period will take place November 1 through November 21, 2014 and your elections will take effect December 1, 2014.

If you are currently enrolled in the plan and **do not want to make changes** to your coverage, **no action is necessary**. Your coverage will continue in the new MagnaCare PPO Network, (in-network benefit only) into the new contract year beginning December 1, 2014.

If you are **not** currently enrolled in the plan and want to enroll or if you want to make changes to your health insurance, you must fill in and submit the enclosed MagnaCare enrollment form to your center bookkeeper for eligibility verification and must be received by the Fund office no later than November 21, 2014.

Enclosed you will find open enrollment materials that describes in detail the medical insurance plan. Please read the materials carefully as there are certain actions that you are required to take during this open enrollment period. Please note this is the only time the Fund will recognize your benefit selections, unless you meet certain Qualifying Life Events which are described in more detail in the enclosed material.

The cost of the new coverage will be shared by you and your employer through payroll deduction based on the category of coverage that you enroll.

Your cost of coverage:

Effective 12/1/2014 Single- $69.61 per month Family - $180.96 per month

2014-2015 Medical Plan Highlights

There will be no changes to your medical coverage. Your copays remain the same and your health insurance will continue, however effective December 1, 2014 MagnaCare will become the new network provider. We encourage you to please read the benefit summaries in this packet carefully. Below are highlights of the plan:

- Primary Care Physician copays are $20 for each visit.
- Specialty Office copays are $20 for each visit.
- Emergency Room copays are $75 per visit; however the copay is waived if you are admitted then the Hospital admission copay applies.
- Prescription Drug coverage copays are $10 for generic drugs, $25 for brand and $50 for non-formulary brand drugs.

Open Enrollment

November 1 - November 21, 2014

If you wish to:

- Continue your current coverage in the MagnaCare PPO Network, (in-network only) and the Welfare Fund; Do nothing your coverage will continue in effect.
- Make changes to your current dependents and coverage category; Fill in the Enrollment/Change form. On the form include the names of the eligible dependents that you wish covered. **Do not include dependents that are not to be enrolled.**
- Enroll in the MagnaCare PPO Network; Fill in the Enrollment/Change form
- Opt-out or disenroll from coverage; Fill in, sign and return the Enrollment Waiver (Opt-out) form to your center's bookeeper

Whatever your decision, please be sure to submit the appropriate form to your center no later than November 21, 2014 for their approval and verification.

Please note this is your only chance during the year to make plan changes for the upcoming plan year unless you experience a Qualifying Life Status Event (see page 1). **Therefore, please follow the instructions carefully and refer to the appropriate parties should questions arise.**

Please contact the Fund office or your center bookkeeper if you have any further questions.

Sincerely,

Randy Paul,
Fund Administrator

Open Enrollment November 1-21, 2014

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your center bookkeeper by November 21, 2014.

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Open Enrollment November 1-21, 2014

If you are currently enrolled in the plan and do not want to make changes to your current coverage, no action is necessary. Your current elections will rollover and continue into the new contract year effective December 1, 2014.

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, be sure to complete and submit the enclosed Enrollment/Change form or Enrollment Waiver form between November 1-21, 2014. If your enrollment is not completed during the open enrollment period, you will have to wait until next year's open enrollment to apply for coverage.

Please note this is the only time you will be allowed to change your benefit elections without experiencing a Qualifying Life Event that will make you eligible for the plan. View page one (1) for more information on Qualifying Life Events.

Open Enrollment Elections Become Effective December 1, 2014

Disclaimer:
This brochure provides only a brief summary of the benefits available under the District Council 1707, Local 95 Head Start Employees Welfare Fund Plan.

Open Enrollment November 1-21, 2014

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your center bookkeeper by November 21, 2014.

ENROLLING IN THE PLAN

How to Enroll

If you are currently enrolled in the plan and ***do not want to make changes*** to your current coverage, ***no action is necessary.*** Your current elections will rollover and continue into the new contract year beginning December 1, 2014.

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your health insurance benefit elections, you **MUST** complete and return to your center bookkeeper a Enrollment/Change form included in this packet by November 21, 2014 to become eligible. Please follow the instructions carefully and refer to the appropriate parties with any questions you may have.

Once you have made your elections, you will not be able to make changes to your benefits until the next open enrollment period unless you experience a Qualifying Life Event that makes you eligible for the plan.

Action is Required!

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the Enrollment/Change form to your center bookkeeper by November 21, 2014 to be enrolled in coverage as of December 1, 2014.

If you do not require coverage, you must complete and return the health insurance Enrollment Waiver form to your center bookkeeper by November 21, 2014.

What Happens if I Don't Enroll

If your enrollment is not completed within the open enrollment period, you will have to wait until the next year's open enrollment period to apply for coverage unless you experience a Qualifying Life Event that makes you eligible for the plan.

Qualifying Life Events

A Qualifying Life Event, as defined by IRS regulations, allows you to make a change to your benefit coverage under a group health plan or health insurance if you experience any of the following:

- Change in status, including but not limited to:
  - Marriage or divorce
  - Death of a dependent
  - Birth or adoption of a dependent
  - Change in employment status
  - Dependent satisfying or ceasing to satisfy plan's eligibility requirements
- Loss of coverage due to but not limited to:
  - Termination of employment
  - Termination of the other plan
  - Death of the employee covered by the plan
  - Legal separation
  - Reduction in the number of hours of employment
- Pursuant to a judgment, decree or court order

Questions?

For questions about member eligibility please contact your center bookkeeper or the Welfare Fund at 212-343-1660.

Open Enrollment November 1-21, 2014

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your center bookkeeper by November 21, 2014.

WHO IS ELIGIBLE FOR WELFARE FUND BENEFITS?

Your Eligibility

You are eligible for Fund coverage if you are an employee of a New York City Head Start delegate agency covered under the Collective Bargaining Agreement or a Participation Agreement between District Council 1707 Head Start Local 95 Community and Social Agency Employees Union ("CSAEU") and the New York City Head Start Sponsoring Board Council, and contributions to the Fund are being made on your behalf. Your coverage begins on the first day of the month following the completion of 30 days of employment; or the first day of the month following the completion of 30 days of employment in which the Fund receives the completed Fund enrollment form, if later.

Management or other Non-Union Employees
Management or other non-union employees of a New York City Head Start delegate agency are eligible for Medical benefits (for certain eligible employees) administered through the Fund.

Your Dependents' Eligibility

Generally, coverage for your dependents begins at the same time your coverage begins, provided that they are enrolled in the family plan and contributions to the Fund are being made on their behalf.

Your eligible dependents are:

- Your spouse (a partner to a marriage legally recognized in the jurisdiction in which it is performed), unless legally separated.
- Your domestic partner*, who is:
    - at least 18 years of age;
    - neither married to you or any other person nor related to you by blood in a manner that would bar marriage in New York State;
    - someone with whom you have a close, committed personal relationship; and
    - someone with whom you currently live and have been living with on a continuous basis.
- Your children whether or not married, until they reach age 26;
    - Group health insurance benefits are available to eligible dependents until the dependent reaches age 26, regardless of their student status, financial dependency, residency, employment or any combination of those factors, except that, prior to January 1, 2014, if the dependent is eligible to receive coverage under a group health plan of the dependent's employer, the dependent will not be eligible for coverage under the Fund's health insurance benefits.
    - Under Michelle's law, a dependent student on a medically necessary leave of absence will continue to be covered for 12 months. This rule will apply to your dependent only if the period of coverage under Michelle's law is greater than coverage provided to eligible dependents until age 26.
    - Your child's spouse and your child's children (your grandchildren) are not eligible for coverage.
- Your unmarried children, regardless of age, who are unable to support themselves because of a physical or mental disability (all as defined under the New York Mental Hygiene Law), provided the incapacitating condition started before age 23;

Open Enrollment November 1-21, 2014

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your center bookkeeper by November 21, 2014.

WHO IS ELIGIBLE FOR WELFARE FUND BENEFITS?

- Your adopted children from the moment of birth, provided that you take custody of the infant as soon as the infant is released from the hospital after birth and an adoption petition is filed with New York State within 30 days of the infant's birth, even if the adoption is not yet final. However, adopted newborns will not be covered from the moment of birth if: (1) the health insurance of the child's natural parents covers the newborn's initial hospital stay; (2) a notice revoking the adoption has been filed; or (3) one of the natural parents revokes their consent to the adoption.

For purposes of eligibility, your dependent children include your stepchildren and the children of your domestic partner.

Your foster children are not eligible for coverage.

*In order to enroll a domestic partner under a benefit plan offered through the Fund, you must present proof evidencing financial interdependence for at least 12 months and provide a copy of a signed and notarized Declaration of Domestic Partnership to the Fund. Contact the Fund office at 212-343-1660 for more information about Domestic Partner benefits.

Adding Eligible Adult Dependents

To add eligible dependents under age 26, who are not currently participating in the plan to your health insurance, you must complete and return the Adult Dependent Election and Eligibility form to your center bookkeeper by November 21, 2014. Adult Dependent Election and Eligibility forms can be obtained by calling the Welfare Fund office at 212-343-1660

TYPES OF COVERAGE

Coverage Available

- **Employee:** covers the employee only.
- **Family:** covers the employee, his/her legal spouse or domestic partner, and their child or children.

The Magnacare PPO, in network benefit offers members exceptional provider choice through an extensive network, with no referrals to specialists needed. In-network coverage only, with access to medical practitioners and acute care hospitals as well as access to physicians and hospitals is available across all 50 states.

MONTHLY CONTRIBUTION RATES

Employee Monthly Contribution Schedule	
Employee	**Family**
$69.61	**$180.96**

Open Enrollment November 1-21, 2014

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your center bookkeeper by November 21, 2014.

OPTING-OUT OF THE PLAN

You may opt-out of enrollment in the Welfare Fund and its benefits if you are enrolled in another insurance plan or cannot afford the cost of coverage by providing the enclosed Enrollment Waiver form signed and returned, to your center bookkeeper for processing. Your disenrollment in the Fund and its benefits will be effective November 30, 2014 provided that we receive the Enrollment Waiver form within the required deadline.

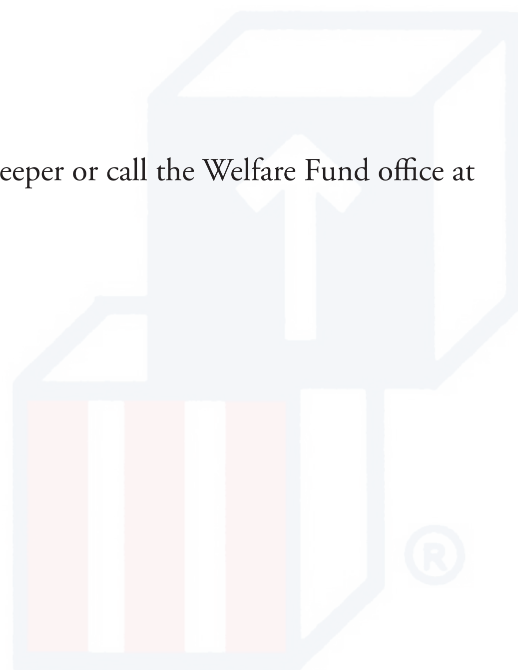
Should you elect not to enroll in the Welfare Fund you will not be able to join the the health insurance plan at a later date until the next open enrollment period unless you experience a Qualifying Life Event that would allow you the opportunity to enroll.

A Qualifying Life Event, as defined by IRS regulations, allows you to make a change to your benefit coverage under a group health plan or health insurance if you experience any of the following:

- Change in status, including but not limited to:
  - Marriage or divorce
  - Death of a dependent
  - Birth or adoption of a dependent
  - Change in employment status
  - Dependent satisfying or ceasing to satisfy plan's eligibility requirements
- Loss of coverage due to but not limited to:
  - Termination of employment
  - Termination of the other plan
  - Death of the employee covered by the plan
  - Legal separation
  - Reduction in the number of hours of employment
- Pursuant to a judgment, decree or court order

If you have any questions regarding this option please contact your center bookkeeper or call the Welfare Fund office at 212-343-1660.

If you do not require coverage, you must sign the health insurance Enrollment Waiver form and return the form to your center bookeeper by November 21, 2014.



Open Enrollment November 1-21, 2014

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your center bookkeeper by November 21, 2014.

MagnaCare PPO In-Network Summary of Health Insurance Benefits

Member Service Phone Number: 1-800-352-6465

Website: www.magnacare.com

Benefit Highlights

	In-Network	Out-of-Network
Office Visit Copay	$ 20 Copay	N/A
Diagnostic Lab Copay Per Visit	$ 0	N/A
Diagnostic Radiology Copay Per Visit	$ 0	N/A
Dependent Office Visit Copay	$ 20 Copay	N/A
Dependent Diagnostic Lab Copay Per Visit	$ 0	N/A
Dependent Diagnostic Radiology Copay Per Visit	$ 0	N/A
Individual Deductible	$ 0	N/A
Family Deductible	$ 0	N/A
Coinsurance	Plan Pays 90% Coins.	N/A
Individual Coinsurance Maximum	$ 1,000 Ind. Coins. Max	N/A
Family Coinsurance Maximum	$ 2,500 Fam. Coins. Max	N/A
Emergency Room Facility Copay	$ 75 Copay	$ 75 Copay
Emergency Room Professional Charge	Coinsurance*	Coinsurance*
Dependent Child Age	Age 26 EOM	Age 26 EOM

Inpatient Hospital Services Performed and Billed by a Hospital

	Limitations	In-Network	Out-of-Network
Inpatient Hospital Coverage	PRECERT: YES	Coinsurance	No Coverage
Skilled Nursing Facility Care	PRECERT: YES	Coinsurance	No Coverage
Inpatient Admission for Medical Rehabilitation (i.e. PT, Physical Medicine and Rehabilitation)	PRECERT: YES 30 days per calendar year	Coinsurance	No Coverage
Hospice Care Inpatient and Outpatient	PRECERT: YES 210 days per lifetime	Coinsurance	No Coverage

Outpatient Hospital Services Performed and Billed by a Hospital or Facility

	Limitations	In-Network	Out-of-Network
Pre-Admission Testing		Coinsurance	No Coverage
Ambulatory Surgery facility charge (free standing)	PRECERT: YES	Coinsurance	No Coverage
Ambulatory Surgery facility charge (OPD hospital)	PRECERT: YES	Coinsurance	No Coverage
Home Health Care Services	PRECERT: YES 200 visits per calendar year	20% Coinsurance	No Coverage
Diagnostic Lab	For dependent copay refer to the Dependent Diagnostic Lab Copay	Coinsurance	No Coverage
Diagnostic Radiology	PRECERT: YES In-Network Radiology Services Only	Coinsurance	No Coverage
Preventive Mammography and Pap Smear & Prostate Screening		Covered in Full	No Coverage

Open Enrollment November 1-21, 2014

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MagnaCare PPO In-Network Summary of Health Insurance Benefits

Member Service Phone Number: 1-800-352-6465

Website: www.magnacare.com

Medical Services performed and billed by a Physician or other Medical Provider			
	Limitations	**In-Network**	**Out-of-Network**
Dependent Office Visit Copay[2]	Coverage effective until end of month	$20 copay	No Coverage
Dependent Diagnostic Lab Copay	Coverage effective until end of month	$0	No Coverage
Dependent Diagnostic Radiology Copay	Coverage effective until end of month	$0	No Coverage
Adult Office Visit Copay[2] Including Outpatient clinic visits		$20 copay	No Coverage
Specialist Office Visits[2]	For dependent copay refer to the Dependent Office Visit Copay	$20 copay	No Coverage
Maternity Pre-Postnatal Care		Covered in Full	No Coverage
Adult Annual Physical Check-Up		Covered in Full	No Coverage
Preventive Mammography and Pap Smear & Prostate Screening		Covered in Full	No Coverage
Chiropractic Care[2]	For dependent copay refer to the Dependent Office Visit Copay	$20 copay	No Coverage
Physical Therapy, Osteopathic Manipulation, Occupational Therapy[2]	30 visits per calendar: For dependent copay refer to Dependent Office Visit Copay	$20 copay	No Coverage
Speech Therapy[2]	10 visits per calendar: For dependent copay refer to Dependent Office Visit Copay	$20 copay	No Coverage
Outpatient Surgery	Office, OP Hospital, Ambulatory Freestanding	Coinsurance	No Coverage[1]
Inpatient Surgery		Coinsurance	No Coverage[1]
Durable Medical Equipment (DME)	PRECERT : YES When amount is > $2,000	Coinsurance	No Coverage
Diagnostic Lab	Providers office / Free Standing Facility; For dependent copay refer to the Dependent Diagnostic Lab Copay	$0	No Coverage[1]
Diagnostic Radiology	Providers office / Free Standing Facility Pre-cert required In-Network only; For dependent copay refer to the Dependent Diagnostic Radiology Copay	$0	No Coverage[1]
Well Baby and Child Care			
	Limitations	**In-Network**	**Out-of-Network**
Well baby and Well Child Care Including Immunizations		Covered in Full	No Coverage
Emergency Coverage			
	Limitations	**In-Network**	**Out-of-Network**
Emergency Room Facility Copay	ER Copay waived if admitted	$75 copay	$75 copay
Emergency Room Professional Charge		Coinsurance*	Coinsurance*

Open Enrollment November 1-21, 2014

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your center bookkeeper by November 21, 2014.

MagnaCare PPO In-Network Summary of Health Insurance Benefits

Member Service Phone Number: 1-800-352-6465

Website: www.magnacare.com

Emergency Coverage			
	Limitations	**In-Network**	**Out-of-Network**
Ground Ambulance		Coinsurance*	Covered at 100% of the usual & customary charge, In-Network Coinsurance
Emergency Admission Facility Charge		Coinsurance*	Coinsurance*
Emergency Admission Professional Charge		Coinsurance*	Coinsurance*
Inpatient Mental Health & Chemical Dependency			
	Limitations	**In-Network**	**Out-of-Network**
Inpatient Mental Health	PRECERT: YES	Coinsurance	No Coverage
Chemical Dependency: Detoxification	PRECERT: YES	Coinsurance	No Coverage
Chemical Dependency: Rehabilitation	PRECERT: YES	Coinsurance	No Coverage
Outpatient Mental Health & Chemical Dependency			
	Limitations	**In-Network**	**Out-of-Network**
Outpatient Chemical Dependency[2]	Up to 30 family visits: For dependent copay refer to the Dependent Office Visit Copay	$20 copay	No Coverage
Outpatient Mental Health[2]	For dependent copay refer to the Dependent Office Visit Copay	$20 copay	No Coverage
Prescription Coverage			
	Deductible Individual / Family	**Deductible Applies to:**	**Retail Threshold**
Pharmacy Deductible / Threshold	No Individual Rx Deductible No Family Rx Deductible	Not Applicable - No Rx Deductible	Not Applicable
	Limitations	**Retail Rx Tier 1 / Tier 2 / Tier 3**	**Mail Order Rx Tier 1 / Tier 2 / Tier 3**
Rx Copay	Deductible, if any must be met before copay applies. Retail Threshold, if any, is the amount MagnaCareRx pays for retail Rx and applies after deductible is met. Once Retail Threshhold has been met by Magnacare, Retail Rx Copay is replaced with 50% coinsurance.	$10/$25/$50	$20/$50/$100

*In-Network emergency services are subject to the In-Network deductible and coinsurance subject to the Network Rate. Out-of-Network emergency services are subject to the same In-Network deductible and coinsurance subject to the Emergent Charge. The Emergent Charge is 100% at 90%ile of Fair Health. Members are responsible for any applicable cost-sharing including the difference between Magnacare's payment and a Non-Participating / Non-Network Provider's charge.

1 - Non participating providers (anesthesiologist, radiologist. pathologist, asst surgeon) in a network hospital, facility, OPD, ambulatory facility or office are subject to the Non Emergent Charge 100% at 90%ile of Fair Health. Members are responsible for any applicable cost-sharing including the difference between Magnacare's payment and a Non-Participating / Non-Network Provider's charge.

2 - Any surgical procedure performed in a provider's office is subject to deductible and coinsurance.

The benefits described here in are only brief highlights of the coverage available. The terms, limitations, conditions, and exclusions of the insurance contract and certificate will govern.

Open Enrollment November 1-21, 2014

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your center bookkeeper by November 21, 2014.

Commonly Asked Health Benefits Questions

How do I find a doctor?

You are able to find a doctor in the MagnaCare network by visiting www.magnacare.com and registering online. Once you are registered and sign in, click on "Find a Doctor." Simply fill in the search criteria and click on "Start Search." From the list of doctors that appears, click on a doctor's name. This will take you to a page with more information about that doctor. Review several profiles until you find a doctor who best meets your needs.

Can I use the "Find a Doctor" tool on the website without registering?

Yes, if you choose not to register, be sure to search within the MagnaCare network. Your network selection is noted on your member ID card for your reference. You have the freedom to use any provider in the MagnaCare PPO Network. With limited exceptions, such as emergency care, your coverage will provide benefits only for covered services rendered by a Network provider. **Out-of-network benefits are not available.**

How do I have a prescription filled?

MagnaCare will be administering the Prescription Drug benefit through MagnaCareRx. You must fill your prescription (written by a MagnaCare participating network doctor) at one of more than 60,000 participating pharmacies nationwide. You will be required to pay a copayment of $10 for generic drugs, $25 for brand name drugs and $50 for non-formulary drugs. You may receive a 90 day supply of approved maintenance medications in the mail through Drugsource Inc., the mail order provider. Fill the first prescription right away at your local participating pharmacy. Submit a second prescription to Drugsource Inc. allowing 10 – 14 business days delivery from Drugsource Inc. Your copays will be $20 for generic, $50 for brand and $100 for non- formulary for a 90 day supply by going through mail order. You may call MagnaCareRx with any questions at telephone 1-888-975-0988.

How do I obtain Durable Medical Equipment (DME) coverage?

DME coverage is a benefit that will be provided through MagnaCare coverage. If it is provided by a participating vendor and authorized in advance. In order for members to obtain DME the physicians office must obtain prior approval from Medical Management unit at 1-888-362-4624.

How can I reach MagnaCare for assistance?

You can reach MagnaCare by calling Customer Service at 1-800-352-6465 Monday through Friday, from 9 am to 5 pm.

What laboratory provider will I use?

To help you keep out-of-pocket expenses as low as possible, use an in-network laboratory provider. Since your MagnaCare coverage does not offer out-of-network benefits, please remind your doctor to use an in-network laboratory.