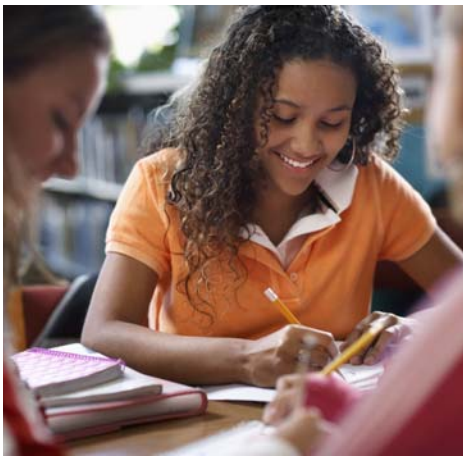
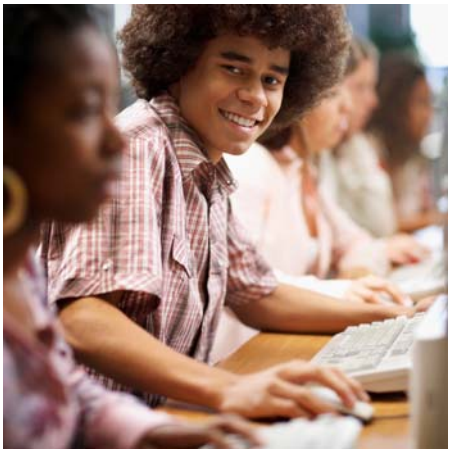
Creative Urban Education





Benefits for the Plan Year

September 1, 2016 — August 31, 2017

Important Medicare Information

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage. Please see page 21 for details.

What's Inside

About this Guide

This is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

Please refer to the insurer booklets for details regarding your coverage, including benefit limitations and exclusions. Creative Urban Education (CUE) reserves the right to amend, modify or terminate any plan at any time and in any manner.

Important Notices

Welcome!

Creative Urban Education spends considerable time evaluating a benefit package for our employees**.**

Each year we review the insurance carriers and the benefit options to be sure that we continue to provide comprehensive programs that are affordable to both Creative Urban Education (CUE) and our employees.

Understanding your benefit options is key to making the best decisions. It is also important to understand the plans so that you receive full value of the coverage provided. Please take some time to carefully review this benefit guide.

Eligibility

Eligible full time employees may enroll certain dependents for coverage under our benefit plans. Eligible dependents include:

- Your legal spouse.
- Your domestic partner. Please contact Orbis for specific eligibility requirements.
- You or your spouse's or domestic partner's children by birth, legal adoption, or legal guardianship, until the end of the calendar year in which they attain age 26.
- Children by birth, legal adoption, or legal guardianship who are age 26 or older and were totally and permanently disabled, either physically or mentally, prior to age 19. They must be unmarried, incapable of self-sustaining employment, dependent upon you for support, and living with you. You must provide physician documentation of the disability prior to age 26.

Paying for Coverage

We sponsor a Section 125 plan that allows you to pay for certain benefits using pre-tax dollars. Contributions are deducted from your paycheck before federal, state, and social security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

Opt-Out Payment

If you decline Medical coverage **because you have coverage elsewhere**, you will receive $1,000 annually, prorated on a per pay basis. This is considered taxable income. You must attest on your enrollment form that you and all of the members of your tax family have or will have Minimum Essential Coverage (MEC). MEC does not include coverage that is purchased in the individual market, whether or not obtained through the Marketplace.

The opt out bonus is not payable if we know or have reason to know that you or any member of your Tax Family does not or will not have the required alternative coverage. Your Tax Family includes you and all other individuals for whom you expect to claim as a personal exemption deduction for the taxable year or years covered by the opt out period.

CUE and Orbis

You will see the name **Orbis** mentioned in various communications. Orbis provides CUE with Human Resource administration support.

Choice of Plans

1. BCBSM Simply Blue PPO
2. Blue Care Network HMO Plan

In Network Benefits	BCBSM PPO Plan	BCN HMO with HRA
Copays	$20 Office visit $150 Emergency Room	$20 Primary Care Physician $40 Specialist office visit $50 Urgent Care $150 after deductible for Emergency Room and High Tech Imaging
Preventive Care Services	Covered at 100%, no deductible or copay	Covered at 100%, no deductible or copay
Deductible, Coinsurance and out-of-pocket maximums		
Deductible Requirement	**Calendar Year:** $500 for one member $1,000 for the family (when two or more members are covered under your contract)	**PLAN YEAR (9/1-8/31):** $ 250 one member $ 500 for the family (when two or more members are covered under your contract) each plan year (9/1-8/31).
Coinsurance percentages *See the detailed benefit charts at the back of this guide*	After the deductible is met, most services are payable at 80%; 50% of approved amount for private duty nursing, mental health and substance abuse services.	After the deductible is met, most services are payable at 80% or 50% of approved amount .
Coinsurance maximum out-of -pocket	$2,500 for one member $5,000 for two or more members each calendar year (	$1,470 one member $2,940 for two or more members each plan year (9/1-8/31)

Important Things to Know about Simply Blue

- Applies deductible and coinsurance to office visits services. Services include, throat culture, blood work, any additional diagnostic services done in the office including surgery. An office visit copay still applies to the exam. **Cost share may not apply during your annual preventive exam.**
- Emergency Room copay is only waived if you are admitted to the hospital
- Out of Network services paid as out of network, even when referred by an in-network doctor

Simply Blue PPO Prescription Plan

BCBSM Simply Blue PPO - Prescription Drug Plan

The Simply Blue PPO prescription drug plan has five different categories, or tiers, of drugs. As the rise of prescription drugs continues in the market we have to take a more aggressive approach on how we cover prescription drugs. This year we are moving the prescription drug program from a 3-tier copay structure to a 5-tier copay structure. Information on where your specific prescription falls on the formulary can be found on the BCBSM website.

The formulary list is updated regularly. A medication may change tiers when a generic equivalent or a lower cost brand drug becomes available. The most current formulary is available on the Blue Cross of Michigan website.

- **Tier 1**— Lowest copay: Drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment. .
- **Tier 2** — Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.
- **Tier 3** — Highest copay: In this category are non-preferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay.
- **Tier 4** — Lowest specialty drug copay: Tier 4 specialty drugs are generally more effective and less expensive than non-preferred specialty drugs in tier 5.
- **Tier 5** — Highest specialty drug copay: These drugs have the highest copay for specialty drugs, usually because there may be a more cost-effective generic or preferred brand available.

BCBS PPO	Current Prescription Copays	Prescription Copays Effective September 1, 2016
Generic	$10	$10
Formulary Brand Name	$40	$40
Non-Formulary Brand Name	$80	$80
Specialty Formulary	NA	15%- Up to a $150 Max
Specialty Non-Formulary	NA	25%- Up to $300 Max

Other features of the plan:

- **Prior Authorization/Step Therapy**- Certain medications require prior authorization, and certain clinical criteria must be met before they will be covered. Step Therapy applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Your pharmacist or doctor can request preauthorization by calling the BCBSM pharmacy help desk.
- **Mail Order Program-** To save money, you may have prescriptions filled through the mail order program for certain maintenance medications. The mail order program allows you to obtain a 90 day supply, delivered to your door, at a lower out-of-pocket cost. You can download Mail Order forms via the BCBS website.
- **Mandatory Generic–** Unless directed by your physician, if you are written a prescription for a brand name prescription and there is a generic available, the pharmacy will fil the generic named prescription

See the BCBS Benefit Summary for other important details about the prescription drug program

Blue Care Network HMO Plan with Health Reimbursement Arrangement (HRA)

You have the opportunity to elect the Blue Care Network HMO plan. Under an HMO plan, you are required to select a primary care physician (PCP).

Your PCP will either perform or coordinate all of the care you receive under this program.

You and each family member may choose a separate PCP from Blue Care Network's list of providers. If you do not use your PCP or have his/her referral for service, you will have no coverage under the plan (except for life threatening illnesses or injuries).

If for any reason you need to change your PCP, you can do so by calling Blue Care Network or visiting the BCN website.

Blue Care Network HMO Plan

The BCN HMO plan has a deductible and coinsurance requirement for certain services. The deductible is $4,000 for a single and $8,000 for a couple or family. However, CUE covers the majority of the deductible. CUE employees and their covered dependents pay only $250 for a single person covered and $500 for two or more people.

- The deductible and 20% co-insurance applies to referred specialist, home health care, in and out patient hospital services, diagnostic lab and x-rays, radiation therapy; 50% coinsurance applies to certain other services.
- Prescriptions are not subject to deductible or co-insurance but have a separate copay depending on the type of the prescription.
- Flat dollar copays do not apply to deductible or co-insurance but rather your overall out of pocket maximum.

The Health Reimbursement Arrangement (HRA)

While the BCN insured plan has a high deductible and coinsurance requirement, the school will be paying for the majority of these costs through a *Health Reimbursement Arrangement (HRA).*

How will the HRA work?

- ***You*** will only be responsible for a plan year (9/1-8/31) deductible of the first $250 for single coverage, or $500 for two person / family coverage for medical procedures only
- Once you have met the deductible, you will be responsible for 20% coinsurance for most inpatient and outpatient services.
- When you have paid the maximum deductible and coinsurance out-of-pocket amount of $1,470 single, or $2,940 for a two person or family contract during the plan year, the HRA will pay for most covered medical expenses that require a deductible or coinsurance.*
- **HRA funds cannot be used for fixed dollar copays, pharmacy, non-covered medical services, dental or vision services. Any remaining funds will not carry over into the next plan year.**

Claim processing is easy!

The HRA is administered by Blue Care Network and ***does not require any further action on your part***.

- Claim expenses over your deductible and coinsurance share are automatically processed from the HRA and paid to your provider.
- When your provider submits a claim to BCN with eligible HRA services, the HRA dollars available to you will be applied automatically. Y*ou do not have to fill out any additional forms or submit any paperwork*.
- Whenever you use a covered service, you will receive an Explanation of Benefits (EOB) statement from Blue Care Network explaining how the HRA dollars were used.

*HRA funds remaining at the end of the plan year will not carry over into the next plan year.

Blue Care Network HMO Plan with Health Reimbursement Arrangement (HRA)

Out-of-pocket	Employee Pays +	HRA Pays =	BCN *Plan Requirement*
Plan Year Deductible and Coinsurance Requirements **(9/1-8/31)**	**Stage 1 – You are responsible for the first:** $ 250 one member* $ 500 two person/family*	**Stage 1—** $0	**Insured Plan Deductible** $4,000 one member $8,000 two person/family
	Stage 2 - After you have met the above Stage 1 deductible, you are responsible for 20% cost sharing, up to a Stage 2 maximum of: $1,220 one member $2,440 two person/family	**Stage 2—After you have met the Stage 1 deductible, the HRA pays 80%**, up to a maximum of: $4,880 one member	**After Stage 1 Deductible, 20% of remaining Deductible and Coinsurance up to a maximum of** $6,100 single $12,200 two person/family
Plan Year Out of Pocket Maximum	$1,470 one member $2,940 two person/family	$4,880 one member $9,760 two person/family	$6,350 one member $13,200 two person/family

Arranging for care while traveling

BCN provides out-of-state urgent care and emergency care through BlueCard®, a Blue Cross and Blue Shield Association program that gives BCN members access to physicians anywhere in the United States outside of Michigan where a Blue plan is offered. If you are traveling outside of Michigan and need treatment for an illness or injury, call BlueCard's 24-hour telephone line at (800) 810-BLUE (2583) for names of participating providers closest to you. If you need urgent care while traveling in Michigan, call your primary care physician. He or she will provide the care you need or direct you to an urgent care center. BCN Customer Service can also help you locate a participating urgent care center.

Patient Protection Disclosure

Blue Care Network HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Care Network designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Care Network at (800) 662-6667.

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

You do not need prior authorization from Blue Care Network or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Care Network at (800) 662-6667.

Blue Care Network (BCN) HMO Plan—Prescription Drugs

Drug Type	Current Benefits	Benefits Effective September 2016
Tier 1A-Value Generics	NA	$4
Tier 1B-Generics	Covered – $10 copay	$15
Tier 2– Preferred Brand	Covered- $40 copay	$40
Tier 3– Non-Preferred Drugs	NA	$80
Tier 4– Preferred Specialty	NA	20% ($200 Max)
Tier 5– Non-Preferred Specialty	Covered – Applicable generic or brand copay will apply	20% ($300 Max)
Mail Order Prescription Drugs	Covered – $20 copay generic, $80 copay brand up to a 90 day supply	Three times applicable copay minus $10

- **Tier 1A** — Lowest copay: Drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment. .
- **Tier 1B—** A second tier of generic prescriptions. Prescriptions in this category cost a bit more than Tier 1A but are still a very cost effective option for treatment.
- **Tier 2** — Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.
- **Tier 3** — Highest copay: In this category are non-preferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay.
- **Tier 4** — Lowest specialty drug copay: Tier 4 specialty drugs are generally more effective and less expensive than non-preferred specialty drugs in tier 5.
- **Tier 5** — Highest specialty drug copay: These drugs have the highest copay for specialty drugs, usually because there may be a more cost-effective generic or preferred brand available.

Some drugs require prior authorization for Blue Care Network HMO members

Certain medications require prior authorization, and certain clinical criteria must be met before they can be dispensed. The criteria for authorization are based on current medical information and the recommendations of Blue Care Network's Pharmacy and Therapeutics Committee.

You may be required to pay additional out-of-pocket costs or a higher copayment if you do not have prior authorization. Your pharmacist or doctor can request prior authorization by calling BCN's pharmacy help desk. There are quantity limits on many prescriptions. The BCN Quantity Limits document provides specific details. Both of these documents are available online at www.bcbsm.com.

Durable medical equipment and diabetic supplies

Blue Care Network uses specialized networks to provide services to members. Your primary care physician determines what you need and writes a prescription. Certain prescriptions may require Blue Care Network authorization. Insulin, needles and syringes are generally part of the Prescription plan.

Medical *equipment* for diabetic patients (such as glucose monitors) and *supplies* (such as lancets and strips) are considered durable medical equipment and may be covered as part of your medical benefit.

Vision Plan

Vision coverage will now be offered by NVA. NVA has an expansive network and offers coverage that is consistent with what was offered to BCBSM.

To find a participating NVA doctor visit, at www.e-nva.com. NVA has a network of over 50,000 participating doctors, including retail chains such as Wal-Mart, Target, and Pearle Vision, among several others.

NVA also offers a Customer Service Call Center available 24 hours a day, seven days a week and 365 days a year.

Eye Essential Plan– offers a discount plan for all plan participants to use if they max out their benefits during the plan year.

Contact Fill– A discount contact lens vendor with full benefit integration (www.contactfill.com)

Benefit	In-Network	Out-of-Network
Exam Once Every 12 Months	Covered 100% After $5 copay	Reimbursed up to $35
Frame Once Every 12 Months	Standard Glass/Plastic Covered 100% After $10 copay	Single Vision up to $30 Bi-focal up to $50 Tri-focal up to $65 Lenticular up to $85
Lenses Once Every 12 Months	Covered up to $130 Retail Allowance (20% discount off remaining balance over $130)	Up to $45
Contact Lenses Once Every 12 Months Elective Medically Necessary	(In lieu of Lenses/Frames) Covered up to $130 Retail Allowance (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $130 Covered 100%	(In lieu of Lenses/Frames) Up to $105 $210

This is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

Dental Plan

Our dental plan is optional and is insured by Blue Cross Blue Shield of Michigan.

You may see any dentist, yet you will save money if you use a Dental Network of America (DNoA) PPO network dentist.

When you receive services from a DNoA dentist, you will usually have the lowest out-of-pocket costs because your copays are based on a discounted amount.

DNoA dentists will also file all claims for you and will receive payment directly from BCBS.

A *non-participating* dentist may balance bill for the additional amount s/he charges for the covered service.

See the BCBS Benefits at a Glance for more details.

Service	Coverage
Deductible (per calendar year) Applies to Class II and Class III services only	$50 per member $100 per family
Class I – Preventive/Diagnostic	100% of BCBS fee
Class II—Basic	75% of BCBS fee after deductible
Class III—Major Restorative ***(there is a 12 month waiting period for benefits from the date coverage is first effective).***	50% of BCBS fee after deductible
	12 month waiting period
Class IV—Orthodontic Services ***(There is a 12 month waiting period for benefits from the date coverage is first effective)*** ***Orthodontic services available for eligible dependents under the age of 19***	50% of BCBS fee after deductible
	12 month waiting period
Benefit Maximum Annual maximum for all services Orthodontics (Lifetime maximum)	 $1,000 per member $1,000 per member

This is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

Flexible Spending Accounts

Flexible Spending Accounts (FSA's) let you pay for health care and day care expenses with tax-free dollars. They help you stretch your money and reduce your federal, state, and Social Security taxes.

There are two types of accounts under this plan: a Health Care Flexible Spending Account (HCFSA) and a Dependent Care Flexible Spending Account (DCFSA). You can enroll in one account or both. Arcadia administers the plan for us.

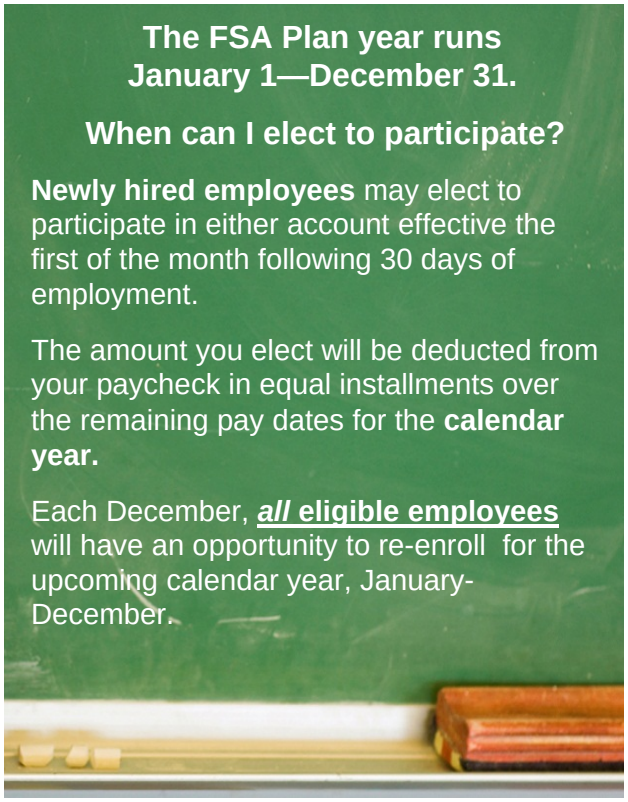
With a HCFSA or DCFSA, you decide before the start of the year how much to contribute to each account. Your contributions are withheld in equal amounts from your paychecks throughout the year. The money is credited to a bookkeeping account(s) set up in your name. Claim the money in your account(s) by submitting a claim form and required documentation for your expenses.

How the Accounts Save You Money

A Flexible Spending Account allows you to pay for qualified expenses with ***pre-tax*** dollars, money that is deducted from your paycheck before taxes are taken out by CUE- saving you 20% to 40% or more. The amount you save depends on your personal income tax bracket.

This chart provides an example of potential savings based on a 15% and 25% tax bracket:

Annual Amount You Contribute to an FSA	Annual Tax Savings in a 15% Tax Bracket	Annual Tax Savings in a 25% Tax Bracket
$ 200	$ 45	$ 65
$ 500	$ 113	$ 163
$1,000	$ 227	$ 327
$1,500	$ 340	$ 490
$2,000	$ 453	$ 653
$3,000	$ 680	$ 980
$4,000	$ 906	$1,306
$5,000	$1,133	$1,633
Savings include 7.65% for the Federal Insurance Contribution Act (FICA). Actual savings will vary based on how many dependents you claim and other factors.		



Flexible Spending Accounts

Here's how the plans work:

- You can participate in the Health Care FSA even if you waive our health coverage.
- You decide, in advance, how much to contribute to each account each plan year.
- You have immediate access to your **full** Health Care FSA election amount on the first day of the plan year (January 1) or for newly hired employees, the first day you are eligible to participate!
- For Dependent Care, you can be reimbursed up to the amount that you have in your account. If you file a claim for more than your balance, you'll be reimbursed as new deposits are made.
- Your contributions are automatically withheld—in equal amounts—from your paychecks through the calendar year. Contributions are credited to an account(s) set up in your name.
- The money may be used to reimburse costs incurred while you are enrolled on the plan. You can't be reimbursed for a claim that was incurred before your effective date, or incurred after the end of the plan year.
- The HCFSA account funds are separate from the DCFSA, and vice versa. The funds are not interchangeable.
- Medical, dental, and vision claims must be submitted to your insurance company first (provided you have insurance).
- Submit a claim form with the itemized receipt or explanation of benefits. When you receive reimbursement, use the funds to pay the provider. You may also pay the provider, and then submit the claim for reimbursement.
- You are reimbursed tax free – so you never pay taxes on the money you set aside in the Flexible Spending Account.
- You have 90 days from the end of the plan year to submit claims incurred during the plan year.

Health FSAs– Rollover Feature

The IRS has recently announced that Health FSAs can now allow a limited carryover of unused account balances of up to $500 from one plan year to the next. We will immediately adopt this new carryover provision for our Health FSAs for the current Plan Year ending 12/31/14.

The carryover takes place after the end of the 3-month period to submit claims (March 31, 2017). Regardless of whether you enroll in the new Plan Year beginning January 1, 2017, if you have a remaining balance for the prior Plan Year, any amounts up to $500 will be carried over to the next Plan Year.

For example, if you have $400 remaining in your 2016 Health FSA as of March 31, 2017 (the end of the run-out period to submit claims for the current Plan Year), but don't enroll during the open enrollment period, you will automatically have $400 allocated to a 2017 Plan Year Health FSA as of April 1, 2017 to use for expenses incurred anytime during the 2017 Plan Year. (This is dependent on the fact that you are still employed as of 12/31/16.)

If you are participating in the Dependent Care FSA (for child or dependent care expenses that you pay to enable you to work), the $500 rollover does NOT apply to this benefit.

If you have any questions about your current account balance(s), feel free to contact Arcadia Benefits Group at (866) 329-4333.

Flexible Spending Accounts

Health Care Flexible Spending Account

The Health Care Flexible Spending Account (HCFSA) helps you pay for medical, dental, and vision bills that aren't covered by insurance. You can set aside up to $1,200. The full amount will be available immediately.

Here are just a few examples of expenses that may be submitted for reimbursement:

Health

- Plan deductibles and coinsurance
- Office visit copays
- Prescription drug copays
- Expenses over the plan maximum
- First aid supplies
- Certain over-the-counter medicines ***if you have a physician's prescription***
  - Antacids
  - Pain relievers
  - Cold medicines
  - Allergy medicine
  - First aid ointments

Dental

- Fillings
- Bridges Crowns
- Orthodontia

Vision

- Exams
- Lenses
- Frames
- Lasik
- Contact lenses
- Contact lens solution

Examples of ineligible expenses:

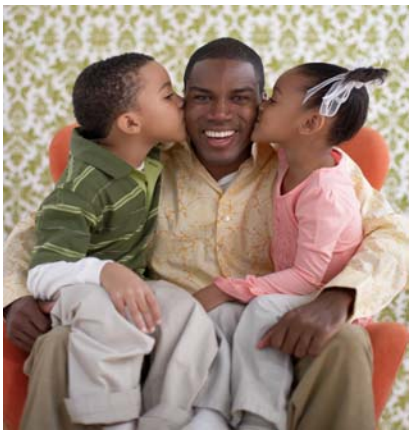
- Cosmetic procedures
- Teeth whitening
- Drugs for cosmetic purposes (Rogaine to treat hair loss)
- Drugs for general good health (like dietary supplements and vitamins)

For a complete list of the expenses eligible for reimbursement, visit the IRS website, call Arcadia, our Third Party Administrator at 866-329-4333, or visit their website at www:arcadiabenefits.com.

Dependent Care Flexible Spending Account (DCFSA)

The DCFSA lets you pay eligible dependent day care expenses with pre-tax dollars. Most child and elder care and companion services are eligible expenses too. Your dependents must be:

- Under age 13 or mentally or physically unable to care for themselves
- Spending at least 8 hours a day in your home
- Eligible to be claimed as a dependent on your federal income tax
- Receiving care when you are at work and your spouse (if you are married) is at work or is searching for work, is in school full-time, or is mentally or physically disabled and unable to provide the care



You can contribute up to $5,000 into your DCFSA, or a minimum contribution of $300. But if both you and your spouse work, the IRS limits your maximum contribution to a DCFSA.

- If you file separate income tax returns, the annual contribution amount is limited to $2,500 each for you and your spouse
- If you file a joint tax return and your spouse also contributes to a DCFSA, your family's combined limit is $5,000
- If your spouse is disabled or a full-time student, special limits apply
- If you or your spouse earn less than $5,000, the maximum is limited to earnings under $5,000

With a DCFSA, you can be reimbursed up to the amount that you have in your account. If you file a claim for more than your balance, you'll be reimbursed as new deposits are made.

Eligible dependent care expenses can either be reimbursed through the DCFSA or used to obtain the federal tax credit. You can't use both options to pay for the same expenses. Usually the DCFSA will save more money than the tax credit. But to find out what is best for you and your family, talk to your tax advisor or review IRS publication 503.

If you contribute to a Dependent Care Flexible Spending Account, you must file an IRS Form 2441 with your Federal Income Tax Return. Form 2441 is simply an informational form on which you report the amount you pay and who you paid for day care.

Disability

Short Term Disability

Our Short Term Disability (STD) program replaces a portion of your income if you are unable to work due to a non-work related illness or injury. The plan is insured by Unum.

The benefit is equal to 60% of your base weekly earnings to a maximum of $1,000 per week. Benefits for approved claims begin on the first day you are disabled due to an accident, or the 8th day if you are disabled due to an illness. Benefits are payable up to 13 weeks, as long as you remain disabled.

Long Term Disability

We offer a Long Term Disability (LTD) plan to provide income to employees who are disabled for an extended period of time. The coverage is insured by Unum; premiums are paid by CUE.

The benefit payable is 66 2/3% of your base monthly earnings to a maximum benefit of $5,000 per month once you have been disabled for 90 days. Claims are subject to approval by Unum.

A disability is defined as during the elimination period (the first 90 days) and the first 24 months, the inability to perform the substantial duties of your regular occupation. After this period, disability is the inability to perform any job that you are suited for by way of education, training, and experience.

Benefits for approved claims are payable for as long as you remain disabled up to age 65 or longer depending on a person's age at disability. The lifetime cumulative maximum benefit period for all disabilities due to mental illness and disabilities based primarily on self-reported symptoms is 24 months.

Item	LTD Benefit
Monthly Benefit	66-2/3% of earnings to a monthly maximum of $5,000. Earnings are base earnings not including overtime pay, bonuses, commissions, etc.
Elimination Period	Benefits begin after 90 days for illness or injury
Benefit Period	Benefits are payable up to age 65 or longer in some cases. Benefits are limited to 24 months in a person's lifetime for mental/nervous conditions or self reported symptoms.
Definition of Disability	For the elimination period and the first 24 months, disability is the inability to perform the substantial duties of your regular occupation. After 24 months, disability is the inability to perform any job that you are suited for by way of education, training, and experience.
Pre-existing Conditions	Benefits aren't payable for a disability that is caused by, or contributed to by a pre-existing condition, if the disability starts before the end of your first twelve months of coverage. A disease or injury is pre-existing if, during the three months before your coverage effective date, 1) it was diagnosed or treated, or 2) services were received for the diagnosis or treatment, or 3) you took drugs or medicines prescribed by a physician for the condition.

This is intended as an easy to read summary. It is not a guarantee of benefits. LTD Claims are subject to approval by Unum. Please review your Unum booklet for the details regarding the benefits payable under this plan, including any exclusions or limitations. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply.

Basic Life/AD&D; Travel Assistance

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

We provide our employees with Basic Life and Accidental Death & Dismemberment (AD&D) benefit insured through Unum at no cost to you. **Your basic life benefit equals one times your base annual salary up to a maximum of $50,000.**

In addition to the life benefit, this plan also includes an accidental death and dismemberment benefit. If your death is determined to be an accident, the Accidental Death & Dismemberment (AD&D) portion of the policy will pay *an additional* 100% of your basic life amount to your beneficiary.

If you lose a limb, or sight in one or both eyes, you may qualify for a percentage of the life benefit under the dismemberment portion of the plan. Please review your Unum booklet with regard to the benefits payable under this plan.

Creative Urban Education pays 100% of the premium for your basic life and AD&D coverage. Life benefits begin to reduce for employees age 70 and older.

Unum Worldwide Emergency Travel Assistance

The Unum worldwide emergency travel assistance services are available to you through Assist America Inc. ***at no cost to you.***

When traveling for business or pleasure, in a foreign country or just 100 miles or more away from home, you and your family (limitations apply) can count on getting help in the event of a medical emergency.

Emergency travel assistance includes help coordinating:

- Hospital admission guarantee (limitations apply)
- Emergency medical evacuation
- Medically supervised transportation home
- Transportation for a friend or family member to join hospitalized patient
- Prescription replacement assistance
- Multilingual crisis management professionals
- Medical referrals to Western-trained, English-speaking medical providers
- Care and transportation of unattended minor child

Inside U.S.:
800-872-1414

Outside U.S.:
+(U.S. access code) 609-986-1234

This is intended as an easy to read summary. It is not a guarantee of benefits. Please review your Unum booklet for the details regarding the benefits payable under this plan, including any exclusions or limitations. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply.

Employee Assistance Program (EAP)

The EAP is a company-sponsored benefit provided by Ulliance, an independent organization, with experienced counseling professionals. Our EAP provides ***confidential*** assistance for you and your eligible family members to help you resolve any concerns that are affecting your personal or work life.

- Family / children problems
- Marital / relationship conflicts
- Stress or other emotional difficulties
- Grief / loss issues
- Child / elder care
- Legal referrals
- Financial resources
- Fitness and nutrition information
- Smoking cessation referrals

Why are EAP services offered?

We all recognize that at some time in our lives each of us will experience some type of personal problem or challenge. Usually we can work out these issues on our own, but sometimes it can be beneficial to have an objective third party help us examine the situation. That's where Ulliance can help. Issues that linger and remain unresolved can often start interfering with many different aspects of our lives: our relationships with others, job performance and personal happiness, to name a few.

What services does Ulliance provide?

Ulliance offers assessment, personal coaching and short-term counseling, as well as crisis intervention and referrals. If you decide that you would like or need services beyond the EAP, your Ulliance counselor will assist you in obtaining continued care, utilizing your healthcare benefits, community resources or sliding fee scale treatment providers.

There are also numerous resources through the Ulliance website. There are articles, assessments, links, local resources and book recommendations on a wide variety of topics.

Using the EAP is confidential, and information is not shared with your supervisor, human resources or co-workers unless you sign a release of information consent form. Ulliance adheres to the laws covering confidentiality.

How much does the EAP cost?

Nothing! CUE provides this benefit to you at no cost. There is no out-of-pocket expense for either you or your eligible family members to use the EAP. If extended counseling is needed beyond the EAP, your healthcare insurance plan provisions may apply.

1-800-448-TEAM (8326)

www.team-eap.com/member

Qualified Changes in Status / Changing Your Pre-Tax Contribution Amount Mid-Year

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year [January 1 – December 31]. The IRS permits you to change your pre-tax contribution amount mid-year only if you experience a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change.

If you do not notify Orbis or Human Resources within 30 days, you must wait until the next annual open enrollment period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to elect or cancel coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

HIPAA Notice of Special Enrollment Rights

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

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

To request special enrollment or obtain more information, contact Human Resources.

The **Children's Health Insurance Program Reauthorization Act of 2009** added the following two special enrollment opportunities:

- The employee's or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided later in this document.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) of 1998 is also known as "Janet's Law." This law requires that our health plan provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Benefits will be payable on the same basis as any other illness or injury under the health plan, including the application of appropriate deductibles, coinsurance and copayment amounts. Please refer to your benefit plan booklet for specific information regarding deductible and coinsurance requirements. If you need further information about these services under the health plan, please contact the Customer Service number on your member identification card.

Michelle's Law

Effective November 1, 2010, if a full-time student engaged in a post-secondary education loses full-time student status due to a severe illness or injury, he/she will maintain dependent status until the earlier of (1) one year after the first day of a medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

Protecting Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

Summary of Material Modification

The information in this document and in the benefit guide applies to the Creative Urban Education Medical Plan, Plan Number 501. This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

Disclosure About the Benefit Enrollment Communications

The benefit enrollment communications (the Guide, the Benefit Plan Notice Requirements document, etc.) contain a general outline of covered benefits and do not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. Creative Urban Education reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents.

Important Notice from Creative Urban Education 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 Creative Urban Education 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. **Creative Urban Education has determined that the prescription drug coverage offered by Blue Cross Blue Shield and Blue Care Network 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 current Creative Urban Education coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current Creative Urban Education coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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 Creative Urban Education 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 Creative Urban Education changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	August 1, 2016
Name of Entity/Sender:	Creative Urban Education
Contact—Position/Office:	Human Resources Department
Address:	485 W. Milwaukee, Detroit, MI 48202
Phone Number:	800-275-6152

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.hip.in.gov
Phone: 1-877-438-4479
All other Medicaid:
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

IOWA – Medicaid
Website: http://www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/ma/
Phone: 1-800-657-3739

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 1-603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

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

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 1-401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

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

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022, ext.15473

WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website:https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Telephone: 1-307-777-7531

To see if any more states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

- U.S. Dept. of Labor, Employee Benefits Security Administration: www.dol.gov/ebsa
  Phone: 1-866-444-EBSA (3272)
- U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services: www.cms.hhs.gov
  Phone: 1-877-267-2323, menu option 4, extension 61565

Contacts

Provider	Benefit	Contact Information	
Orbis	Human Resources Administrator	Amy Wentrack / Kenzie Achatz	800-275-6152
BCBSM	Medical PPO	Claim and eligibility questions	(877) 790-2583
		To find PPO providers	(800) 810-2583 www.bcbsm.com
		Pharmacy questions	(800) 922-1557
BCN	Medical HMO	General info	(800) 662-6667 www.mibcn.com
BCBS/BCN	Dental	Dental Network of America (DNoA)	(888) 826-8152 www.bcbsm.com
NVA	Vision	Member Services	(800)672-7723 www.e-nva.com
Unum	Basic Life/AD&D	Benefit and claim information	800-445-0402 www.unum.com
Unum	Disability	Benefit and claim information	800-858-6843 www.unum.com
Arcadia	Flexible Spending Account	Benefit and claim information	(866) 329-4333 www.arcadiabenefits.com
Ulliance	EAP	Employee Assistance Program	(800) 448-8326 www.team-eap.com
Unum / Assist America, Inc.	Travel Assistance	Inside U.S.: 800-872-1414 Outside U.S.: +(U.S. access code) 609-986-1234	www.unum.com/travelassistance