Global Educational Excellence
2017 Benefits and Enrollment Guide

July 1, 2017 to June 30, 2018

STERLING INSURANCE GROUP

Health | Dental | Vision

2017 Benefits Summary Guide Overview

Global Educational Excellence offers eligible employees a variety of benefits that can provide you and your family with health care coverage and financial protection, tailored to best fit your needs. Our benefits program is an important part of your overall compensation and with the assistance of Sterling Insurance Group, we are regularly assessing the quality and cost of the benefits to ensure we offer the most competitive package possible. Changes and relevant new information are highlighted below, however, we encourage you to review this guide in its entirety.

Contents

Open Enrollment: Enrollment is available in June for a July 1st effective date. This is the only opportunity you will have this year to make changes to your benefit elections. During this period you may add, drop, or modify coverage. You will be locked into the plan selections for one year unless there is a qualifying event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status). All changes must be made within 30 days of the event or you will need to wait until the next open enrollment period.

- **Healthcare: Blue Cross Blue Shield Blue Care Network** 

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- **Dental: Delta Dental (no change)**
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- **Vision: EyeMed Vision Care** 

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 15 for more details.

This booklet is intended for illustrative and informational purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern. The Global Educational Excellence reserves the right to change or terminate at any time, in whole or in part, the employee benefit package, with respect to all or any class of employees, former employees and retirees.

Eligibility Overview

Global Educational Excellence is pleased to offer its employees an excellent benefits program. These health and welfare benefits are designed to protect you and your family while you are an active employee.

- **Medical** - Coverage is offered to employees who work 30 or more hours per week. Coverage begins on the first day of the month following 60 days from your date of full-time employment. You may cover your children up to age 26 regardless of student status. Coverage continues to the end of the year in which they turn 26.
- **Dental** - Coverage is offered to employees who work 30 or more hours per week. Coverage begins on the first day of the month following 60 days from your date of full-time employment. You may cover your unmarried children up to age 19 or 24 if they have fulltime student status. Coverage continues to the end of the calendar year in which they turn 24.
- **Vision -** Coverage is offered to employees who work 30 or more hours per week. Coverage begins on the first day of the month following 60 days from your date of full-time employment. You may cover your children up to age 26 regardless of student status. Coverage continues to the end of the year in which they turn 26.
- **It is your responsibility** to provide GEE's Benefits Administrator with proof of your dependents' eligibility, in the form of: (a) marriage license, (b) Court order specifying your responsibility to provide "group health care coverage" to your dependent children, (c) copy of birth certificate or (d) class schedule if dependent is between the ages of 19-26.

New employees have up to 30 days after their eligibility to enroll. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period.

Annual Elections: It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period. Exceptions will be made for changes in family status during the year, allowing you to make a mid-year benefit change. A family status change includes:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Change in your spouse's employment or
- Loss of coverage by a spouse

If you have a family status change, you must change your benefit elections within 30 days of the qualifying event, or you will need to wait until the next annual open enrollment period.

COBRA Continuation Coverage: When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

HMO and PPO Healthcare Benefits

Healthcare benefits are one of the most important and necessary parts of your benefit package. The following is a summary of your benefits offered through Blue Cross Blue Shield and Blue Care Network. For a more detailed explanation of benefits, please refer to your certificate of coverage. You may access a list of participating providers through the carrier's website located on page 22 of this guide.

	HMO Core Plan	HMO Buy Up Plan	PPO Buy Up Plan	
	In-Network	In-Network	In-Network	Out-of-Network
Deductible (Calendar Year) **Individual / Family**	$500 / $1000	$250 / $500	$1,500 / $3,000	$3,000 / $6,000
Coinsurance	90%	100%	80%	60%
Annual Coinsurance Maximum **Individual / Family** (includes coinsurance only)	$1,000 / $2,000	N/A	$2,500 / $5,000	$5,000 / $10,000
Annual Out-of-Pocket Maximum **Individual / Family** (includes deductible, copays, coinsurance and prescription drugs)	$6,600 / $13,200	$6,600 / $13,200	$6,350 / $12,700	$12,700 / $25,400
Office Visit	$20 copay	$20 copay	$30 copay	60% after deductible
Specialist Visit	$30 copay	$30 copay	$30 copay	60% after deductible
Emergency Room	$150 copay	$150 copay	$150 copay	
Chiropractic (20 visits per calendar year)	$30 copay	$30 copay	$30 copay	60% after deductible
Urgent Care	$35 copay	$35 copay	$30 copay	60% after deductible
Prescription Drugs - 30 day supply	$15 / $50	$15 / $50	$10 / $40 / $80	See BCBS benefits-at-a-glance summary
Mail Order Prescription Drugs - 90 day supply	2x copay	2x copay	$20/ $80/ $160	See BCBS benefits-at-a-glance summary

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Opt Out Bonus Information

If you have access to healthcare coverage through another source, you have the option to waive participation in the Global Educational Excellence medical and/or dental plans. Opt Out Bonus dollars are available as follows:

Waive Medical Only	Waive Dental Only	Waive both Medical and Dental
Opt Out Bonus	**Opt Out Bonus**	**Opt Out Bonus**
$2,000 per year	**$1,000 per year**	**$3,000 per year**
Opt Out Bonuses are pro-rated and paid on a monthly basis Opt Out Bonuses are taxable and will be included in your W-2 wages		
To be eligible to receive Opt Out Bonus dollars you must: ▪ Make your waiver elections through the BenefitsConnect online enrollment system ▪ Provide proof that you are enrolled in another plan (applies to Medical only)		

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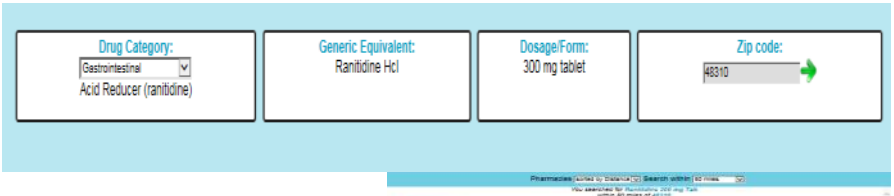
Medtipster Online Tool Overview

The ultimate pharmacy search engine for discounted generic drug programs available at pharmacies throughout the USA.

Simply go to www.medtipster.com and click on “Enter Medtipster” and begin saving money.

It’s as easy as



Enter the name, dosage, and your zip code to find the best deal for your generic prescription…

You can also find a therapeutic alternative search at a specific pharmacy or sufficient a pharmacy.

Today, pharmacies all across the U.S. have implemented **$4 generic drugs programs**. The question many people ask themselves is, "which pharmacy has my prescription on their **$4 generic drugs program**?" Medtipster.com was designed to answer that question, without sending users through a multiple step process to obtain the answer. **Cheap prescription drugs** are available for more than 70% of written prescriptions. **Generic drugs** are distributed as the bioequivalent to the brand name, and today are more commonly distributed to consumers when and where available. Talk to your doctor if you have specific questions about your prescription and the alternative of a generic equivalent.

Finding the **cheapest prescriptions** is as easy as 1-2-3 with Medtipster.com's proprietary technology. You will never again have to wonder which pharmacy's generic program has your prescription drug. Have your healthcare and afford it, too.

Other search types include…

- Flu Shots
- Immunizations
- Health Screenings

ask PharmaSueAnn™ LIVE
pharmasueann™

The world of healthcare is both confusing and expensive. Global Educational Excellence Medtipster provides access to pharmasueann. She posts a blog designed to clear things up. To tell it to you straight. To help you navigate through the morass with a little savvy and a lot less stress. From time to time, perhaps even to evoke a smile.

You will get some very concrete advice. Discover steps you can take to avoid the Medicare donut hole. Get tips for managing your care in the hospital. Learn about the background on some of the issues in drug trials.
Healthcare is complicated. Every little bit of knowledge helps!

PharmaSueAnn is here to serve you.

Dental Benefits Overview

Dental coverage is provided by Delta Dental. You may access a list of participating providers through the carrier's website located on page 22 of this guide.

	Delta Dental Dental PPO Point-of-Service Plan
	(PPO Dentist) In-Network
Deductible (Benefit Year) **Individual / Family**	$50 / $150
Class 1—Preventative Services: Oral Exams, X-Rays, Cleaning, Sealants	100% Coverage *(deductible waived)*
Class 2—Basic Services: Fillings, Endodontic & Periodontal Services, Simple Extractions, Root Canal Therapy	80% after deductible
Class 3—Major Services: Inlays, Onlays, Crowns, Dentures, Bridgework	50% after deductible
Class 4—Orthodontics	Not Covered
Maximum Benefit:	
Benefit Maximum all Classes	$1,000

You may offer dental coverage to your unmarried children up to the age of 19 or 24 if they are a full-time student. Coverage ends the end of the calendar year.

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Voluntary Vision Benefits Overview

Vision coverage is provided by EyeMed Vision Care. You may access a list of participating providers through the carrier's website located on page 22 of this guide.

	EyeMed Vision Care Insight Network
	(PPO Dentist) In-Network
Exam (every 12 months)	$10 copay
Frames (every 24 months)	$130 allowance 20% off balance of $130
Contact Lenses (every 12 months)*	$130 allowance 15% off balance over $130
Standard Plastic Lenses (every 12 months)*	
Single Vision	$25 copay
Bifocal	$25 copay
Trifocal	$25 copay
Lenticular	$25 copay
Progressive	$90-$135 copay, based on Tier
*One set of lenses every 12 months - contact lenses -or- standard plastic lenses	

You may offer dental coverage to your unmarried children up to the age of 19 or 24 if they are a full-time student. Coverage ends the end of the calendar year.

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Insurance Definitions

ANNUAL MAXIMUM COST: The most you will pay for approved benefits in a benefit year. Also referred to as the annual "out-of-pocket" maximum.

ANNUAL MAXIMUM BENEFIT: The most your plan will pay for approved benefits in a benefit year.

CARRIER: The insurance company (i.e. HAP, Delta Dental).

CLAIM: A bill submitted to your carrier for payment.

COPAY: The amount you pay for a benefit (i.e. prescriptions/office visits - $6, $40, $60).

COINSURANCE: The percentage of costs you pay for a covered service (i.e. 10%, 20% or 30%).

COORDINATION OF BENEFITS: Your insurance combined with another (spouse) insurance company.

DEDUCTIBLE: The amount you pay first before your insurance company pays for your services.

EFFECTIVE 5/01/2015: The day and month your benefits are activated.

EOB (Explanation of Benefits): Information you receive explaining how your claim was processed.

HMO (Health Maintenance Organization): A network where you choose one participating doctor.

IN-NETWORK: A group (network) of Doctors, labs, or hospitals that 'participate' with network carriers, and agree to accept the payment offered by the insurance carrier.

MAIL ORDER DRUGS: Prescription drugs are received through the mail.

MAINTENANCE DRUGS: Prescription drugs that must be taken regularly (i.e. insulin, high blood pressure).

OUT-OF-NETWORK: Doctors, labs or hospitals that do not 'participate' with some insurance carriers.

PCP (Primary Care Physician): A network doctor that you choose 'participates' in a network plan.

PPO (Preferred Provider Organization: A network plan of doctors, labs and hospitals.

PROVIDER: The doctor, lab or hospital (i.e. participating providers in HMO, POS or PPO plans).

REIMBURSEMENT: The amount returned to you after a claim form has been submitted for payment.

TRADITIONAL: You can usually choose any doctor, lab or hospital for service.

VOLUNTARY: You agree to pay for the insurance coverage offered through your employer.

Important Disclosure Notices

NOTE TO ALL EMPLOYEES:
Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

Global Educational Excellence
Gadeer Dari
2455 S. Industrial Highway, Suite A
Ann Arbor, MI 48104

THIS DOCUMENT IS FOR INFORMATION PURPOSES ONLY
This communication is intended for illustrative and information purposes only. The plan documents, insurance certificates, and policies will serve as the governing documents to determine plan eligibility, benefits, and payments.

LIMITATIONS AND EXCLUSIONS
Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

ALL RIGHTS RESERVED
Global Educational Excellence reserves the right to amend, modify, or terminate its insurance and benefit plans at any time, including during treatment.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS
If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.
(a.) If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.
However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.
(b.) You are eligible to enroll yourself and your Eligible Dependent in the Medical Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.
(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:
(1.) Your or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or
(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.
(d.) You are eligible to enroll yourself and your Eligible Dependents in the Plan during an Open Enrollment Period. Your enrollment will become effective on the 1st day of the Plan Year following the Open Enrollment Period.
(e.) You may enroll in the Plan an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.
(f.) You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permitted under the applicable Benefits Guide (and subject to the Cafeteria Plan rules outlined in Section 125 of the Internal Revenue Code).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for a dependent under the age of 26; or within the deadline established by the Plan Administrator for Open Enrollment Period).

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

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NOTICE REGARDING PRE-EXISTING CONDITIONS
The Global Educational Excellence Group Health Plan (the "Plan") does not impose a pre-existing condition limitation as detailed in the Benefit Guide issued by the insurance carrier. Please review the Benefits Guide carefully (you can obtain another copy of it by contacting the Plan Administrator). The following provides an overview of the pre-existing condition limitation that is allowed under the Health Insurance Portability and Accountability Act (HIPAA) as well as protections provided under the Patient Protection and Affordable Care Act of 2010 (PPACA). If the Plan does not impose a pre-existing condition limitation, much of this information does not apply to you; however, this information is provided to make you aware of this important legislation.
The Plan complies with the changes set forth in the PPACA of

Important Disclosure Notices

2010 and does not impose pre-existing condition exclusions with respect to eligible dependent children who are under 19 years of age. In accordance with PPACA, this change was effective as of the first day of the Plan Year beginning on or after September 23, 2010; and will apply to all other covered individuals on the first day of the Plan Year beginning on or after January 1, 2014.
Pre-existing condition exclusion means that if you have a medical condition before enrolling in the medical program, you might have to wait a certain period of time before the medical program will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month look-back period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a new hire waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the medical program or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption.
This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. **To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should promptly give the Plan Administrator a copy of any certificate of creditable coverage (HIPAA Certificates) you have**. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or insurer. There are also other ways that you can show that you have creditable coverage. Please contact the Plan Administrator if you need help demonstrating creditable coverage.
Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator (with the assistance of the prior plan administrator or insurer) to determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment, and may result in a loss of coverage under this Plan and other employment disciplinary action.

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN:
HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card. If you are unable to obtain the certificate of coverage through the carrier, or have other questions regarding Pre-existing Conditions, please contact the Plan Administrator for assistance at the address or phone number below.

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NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)
On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.
The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.
The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING MICHELLE'S LAW
On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.
The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The

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certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

MEDICARE NOTICE

You must notify Global Educational Excellence when you or your dependents become Medicare eligible. Global Educational Excellence is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

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NOTICE REGARDING PATIENT PROTECTION RIGHTS

The Global Educational Excellence group HMO Health Alliance Plan does a require members to designate a Primary Care Physician. The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician.

One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. 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 or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

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IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by 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 Global Educational Excellence 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:

- 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.

Important Disclosure Notices

- Global Educational Excellence has determined that the prescription drug coverage offered by their carrier's Benefits 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. If 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 coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 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 your HR Representative. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your company 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, visit Social Security at www.socialsecurity.gov, or call 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 require to pay a higher premium (penalty).

Global Educational Excellence
Gadeer Dari
2455 S. Industrial Highway, Suite A
Ann Arbor, MI 48104
(734) 369-9500

Important Disclosure Notices

The Plan's Pledge Regarding Health Information

The Plan is committed to protecting your personal health information. The Plan is required by law to protect medical information about you. This notice applies to medical records and information the Plan maintains concerning the Plan. Your personal doctor or health care provider may have different policies or notices regarding the use and disclosure of your health information created in his or her facility. This notice will describe how the Plan may use and disclose health information (known as "protected health information" under federal law) about you, as well as the Plan's obligations and your rights regarding this use and disclosure.

Use and Disclosure of Health Information

The following categories describe different ways that the Plan uses and discloses protected health information. The Plan will explain and present examples for each category but will not list every possible use or disclosure. However, all of the permissible uses and disclosures fall within one of these categories:

- *For treatment:* The Plan may use or disclose your health information to facilitate treatment or services by providers. For example, the Plan may disclose your health information to providers, including doctors, nurses, or other hospital personnel who are involved in your care.
- *For payment:* The Plan may use and disclose your health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, or to determine benefit responsibility under the Plan. For example, the Plan may disclose your health history to your health care provider to determine whether a particular treatment is a qualifying health expense or to determine whether the Plan will reimburse the treatment. The Plan may also share your health information with a utilization review or precertification service provider, with another entity to assist with the adjudication or subrogation or health claims, or with another health plan to coordinate benefit payments.
- *For Health Care Operations:* The Plan may use and disclose your health information in order to operate the Plan. For example, the Plan may use health information in connection with the following: (1) quality assessment and improvement; (2) underwriting, premium rating, and Plan coverage; (3) stop-loss (or excess-loss) claim submission; (4) medical review, legal services, audit services, and fraud and abuse detection programs; (5) business planning and development, such as cost management; and (6) business management and general Plan administration.
- *To Business Associates and Subcontractors:* The Plan may contract with individuals and entities known as business associates to perform various functions or provide certain services. In order to perform these functions or provide these services, business associates may receive, create, maintain, use, or disclose your health information, but only after they sign an agreement with the Plan requiring them to implement appropriate safeguards regarding your health information. For example, the Plan may disclose your health information to a business associate to administer claims or to provide support services, but only after the business associate enters into a Business Associate Agreement with the Plan. Similarly, a business associate may hire a subcontractor to assist in performing functions or providing services in connection with the Plan. If a subcontractor is hired, the business associate may not disclose your health information to the subcontractor until after the subcontractor enters into a Subcontractor Agreement with the business associate.
- *As Required by Law:* The Plan will disclose your health information when required to do so by federal, state, or local law. For example, the Plan may disclose health information when required by a court order in a litigation proceeding, such as a malpractice action.
- *To Avert a Serious Threat to Health or Safety:* The Plan may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. The Plan would disclose this information only to someone able to health prevent the threat. For example, the Plan may disclose your health information in a proceeding regarding the licensure of a physician.
- *To Health Plan Sponsor:* The Plan may disclose health information to another health plan maintained by the Plan sponsor for purposes of facilitating claims payments under that plan. In addition, the Plan may disclose your health information to the Plan sponsor and its personnel for purposes of administering benefits under the Plan or as otherwise permitted by law and the Plan sponsor's HIPAA privacy policies and procedures.

Special Situations: The Plan may also use and disclose your protected health information in the following special situations:

- *Organ and Tissue Donation:* The Plan may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- *Military and Veterans:* If you are a member of the armed forces, the Plan may release your health information as required by military command authorities. The Plan may also release health information about foreign military personnel to the appropriate foreign military authority.
- *Workers' Compensation:* The Plan may release health information for Workers' Compensation or similar programs that provide benefits for work-related injuries or illnesses.
- *Public Health Risks:* The Plan may disclose health information for public health activities, such as prevention or control of disease, injury, or disability; report of births and deaths; and notification of disease exposure or risk of disease contraction or proliferation.
- *Health Oversight Activities:* The Plan may disclose health information to a health oversight agency for activities authorized by law, e.g., audits, investigations, inspections, and licensure, which are necessary for the government to monitor the health care system, government programs, and

Important Disclosure Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants
Phone (Outside Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602.417.5437

COLORADO – Medicaid and CHIP
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

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

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

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

LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741

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

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

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

MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

Important Disclosure Notices

STATES OFFERING PREMIUM PAYMENT ASSISTANCE PROGRAMS , continued

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-800-383-4278

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: 603-271-5218

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

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: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

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

OREGON – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.ohhs.ri.gov
Phone: 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
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

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

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

WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

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.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2017)

Important Disclosure Notices

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or
Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your spouse dies;
Your spouse's hours of employment are reduced;
Your spouse's employment ends for any reason other than his or her gross misconduct;
Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

The parent-employee dies;
The parent-employee's hours of employment are reduced;
The parent-employee's employment ends for any reason other than his or her gross misconduct;
The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
The parents become divorced or legally separated; or
The child stops being eligible for coverage under the Plan as a "dependent child."

Important Disclosure Notices

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;

The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Aniseh Issa.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Important Disclosure Notices

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Global Educational Excellence Plan
Gadeer Dari
2455 S. Industrial Highway, Suite A
Ann Arbor, MI 48104
(734) 369-9500

Important Disclosure Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 2-28-18)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Aniseh Issa.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Important Disclosure Notices

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Global Educational Excellence	4. Employer Identification Number (EIN) 38-3418987	
5. Employer address 2455 S. Industrial Highway, Suite A	6. Employer phone number (734) 369-9500	
7. City Ann Arbor	8. State MI	9. ZIP Code 48104
10. Who can we contact about employee health coverage at this job? Gadeer Dari		
11. Phone number (if different from above)	12. Email address benefits@gee-edu.com	

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

As your employer, we offer a health plan to:

- All full-time eligible employees.

With respect to dependents:

- We do offer coverage. Eligible dependents are:
  - Legally married spouse as defined by the State
  - Dependent child(ren) as defined by the IRS

- This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Contact Information

Benefit Consultant

General Claims and Benefit Information

Customer Service Hotline: In order to help you with your benefit questions, claim issues, and general inquiries, you and your dependents may contact Sterling Insurance Group. Sterling Insurance Group is a one-source helpline for all of your benefit questions. Please call the toll-free number listed below and speak to a customer service specialist who knows your benefit plan and can help with any questions.

Toll Free: (844) 599-9500

www.sterlingagency.com

Healthcare	Health Alliance Plan (HMO) Alliance Health and Life (PPO)	Group Number 10000806	(800) 422-4641 (888) 999-4347	www.hap.org
Dental	Delta Dental	Group Number 3380	(800) 524-0149	www.deltadentalmi.com
Vision	EyeMed Vision Care	Group Number	(866) 939-3633	www.eyemedvisioncare.com

When contacting any of the companies above it is important to have the Insurance card or I.D. number (s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, i.e. Explanation of Benefits, denial letter, receipts, etc.

Summary of Benefits Coverage