2021

PLAN YEAR

OPEN ENROLLMENT GUIDE

GLWA

Great Lakes Water Authority

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October 26, 2020

Team Members:

If 2020 has taught us anything, it is that a strong and healthy body can keep us moving through a pandemic, with minimal illness. As we enter Open Enrollment, November 5, 2020, through November 20, 2020, for the 2021 Plan Year, we want to be your partner in wellness.

During this unprecedented time, we realized we are much stronger than we ever imagined. Focusing on the positive and all that we have to be grateful for, helps to keep our health in check. With so many changes, restrictions, losses, and new ways of living this year, many of us have noticed that we have been a little unsettled from time-to-time. When that occurs, let's make a commitment to refocus to do all we can to end this year strong. Let's challenge ourselves to start the new year stronger and healthier, laser-focused on wellness and our well-being.

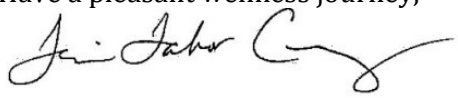
As your partner in wellness, we encourage you to:

- Schedule and keep annual physical appointments with your primary doctor;
- Visit the dentist before there is pain;
- Get a flu shot, wear a mask and keep your distance;
- Take advantage of all the benefits GLWA offers to you and your dependents directly, and in conjunction with the healthcare providers you have chosen.

GLWA contributes 80 percent of the total cost of your health care coverage, while you contribute 20 percent of the total cost. For the 2021 Plan Year, the cost to maintain the coverage provided under the BCBSM and HAP plans have increased due to a market trend of cost increases from 2020 to 2021. We are glad to share that we are moving our dental benefits from BCBSM to Delta Dental of Michigan. Included in this packet is the 2021 Health Care Per Pay Contributions spreadsheet which also includes the 2020 costs for your reference.

We know that good health can affect your wallet in a positive way by decreasing the need for out-of-pocket expenses. I invite you to join your fellow GLWA team members in challenging yourself to care for yourself. Participate in the beneficial programs offered through our carriers, like Omada for heart health, Livongo for diabetes management, financial health, emotional wellbeing and even fitness equipment discounts. We can end this year healthier than we are today. Choose your own goal. Your wellness, your way. Remember each day we have a new opportunity to improve our wellness. Keep working on wellness. We are hopeful that the information in this booklet will help you.

Have a pleasant wellness journey,



Terri Tabor Conerway
Chief Organizational Development Officer

2021 Health Care Per Pay Contributions

BCBSM Medical - 2021 Per Pay Contributions			
BCBSM PPO*	**Team Member Pays**	**Pays**	
Member Only	$63.61	$254.44	
Member + 1	$133.58	$534.33	
Member + 2 or more	$178.11	$712.43	14% increase
** Prescription Drug coverage provided by CVS Caremark*			

HAP Medical - 2021 Per Pay Contributions			
HAP HMO	**Team Member Pays**	**Pays**	
Member Only	$64.07	$256.26	
Member + 1	$134.54	$538.15	
Member + 2 or more	$179.38	$717.53	6.7% Increase

DELTA DENTAL - 2021 Per Pay Contributions			
DELTA DENTAL	**Team Member Pays**	**Pays**	
Member Only	$2.50	$9.99	
Member + 1	$4.99	$19.97	
Member + 2 or more	$8.74	$34.94	5.6% decrease

HERITAGE VISION - 2021 Per Pay Contributions				
	BASIC PLAN		**BUY-UP PLAN**	
HERITAGE VISION	**Team Member Pays**	**Pays**	**Pays**	**Pays**
Member Only	$0.51	$2.05	$1.52	$2.05
Member + 1	$0.51	$2.05	$3.71	$2.05
Member + 2 or more	$0.51	$2.05	$7.22	$2.05

No change

2020 Health Care Per Pay Contributions

BCBSM Medical - 2020 Per Pay Contributions		
BCBSM PPO*	**Pays**	**Pays**
Member Only	$55.81	$223.24
Member + 1	$117.20	$468.80
Member + 2 or more	$156.26	$625.06
** Prescription Drug coverage provided by CVS Caremark*		

HAP Medical - 2020 Per Pay Contributions		
HAP HMO	**Pays**	**Pays**
Member Only	$60.02	$240.08
Member + 1	$126.04	$504.17
Member + 2 or more	$168.06	$672.21

BCBSM Dental - 2020 Per Pay Contributions		
BCBSM DENTAL	**Pays**	**Pays**
Member Only	$2.64	$10.58
Member + 1	$5.29	$21.16
Member + 2 or more	$9.26	$37.03

HERITAGE VISION - 2020 Per Pay Contributions				
	BASIC PLAN		**BUY-UP PLAN**	
HERITAGE VISION	**Pays**	**Pays**	**Pays**	**Pays**
Member Only	$0.51	$2.05	$1.52	$2.05
Member + 1	$0.51	$2.05	$3.71	$2.05
Member + 2 or more	$0.51	$2.05	$7.22	$2.05

NEW FOR 2021

Welcome to 2021 Open Enrollment!

GLWA is pleased to announce exciting enhancements to its benefit program offering, effective January 1, 2021. Please read below for a general overview, and flip to each respective section for more information. Complete details can be found in each carrier benefit summary.

What's New for 2021?

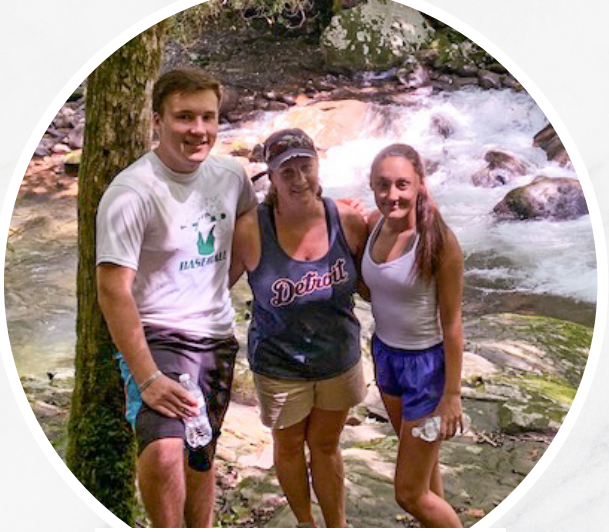
Beginning January 1, 2021, GLWA dental coverage is moving from Blue Cross Blue Shield of Michigan to Delta Dental of Michigan:

- Why the change – To resolve increasing number of issues related to claims processing and dependents dropping from the plan in error.
- Our dental benefits will remain the same – Our annual maximum benefit per person remains $1,000. Preventive care will remain covered outside of the $1,000 annual benefit maximum, so that you have the full $1,000 available for other dental services.
- Most dental providers participate. To confirm your dental provider participates in either the Delta Dental PPO or Premier networks, email your dental provider's name and phone number to onewaterwellness@glwater.org or call 313.964.9555. We will confirm participation, or work with your dental provider to enroll them with Delta Dental.

Cover Credit: David Jahn, Electrical Instrumentation Control Technician (E), Lake Huron and Shamarri Riddle, Chemist, Water Works Park

System Analytics and Metered Operations Professional Administrative Analyst Molly Sullivan used her GLWA water bottle while traveling through Europe.

Procurement Management Professional Mahufz Rahman and his wife enjoying beautiful scenery in Langkawi, Malaysia.



You're a valued GLWA team member and your health and well-being are important to us. We are proud to provide you and your dependents with valuable and significant benefits. This guide is an overview of the benefits available to you, and their impact on your total compensation. Please read it carefully in order to make the best choices for you and your family in the 2021 plan year. Please consult your Organizational Development (OD) team member with any questions.

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See **page 25** for important information concerning Medicare Part D coverage.

GLWA's 2020 Drinking Water Week Photo Contest Winner Planning Services Manager Sherri Gee with her family on vacation in the Smoky Mountains.

In this Guide, we use the term Company to refer to Great Lakes Water Authority. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

ELIGIBILITY & ENROLLMENT

You and your family have unique needs, which is why GLWA offers a variety of benefit plans from which you may choose. If applicable, please make sure to consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

Open Enrollment will be held November 5 to November 20, 2020.

If you are a full-time team member of GLWA who is regularly scheduled to work a minimum of 40 hours per week, you are eligible to participate in the medical, dental, vision, life and disability plans, as well as other additional benefits.

When Does Coverage Begin?

For annual open enrollment, the elections you make are effective January 1, 2021. *Due to IRS regulations, once you have made your choices for the 2021 plan year, you won't be able to change your benefits until the next enrollment period unless you experience a qualifying life event.*

Eligible Dependents

Dependents eligible for coverage in the GLWA benefits plans include:

- Your legal spouse;
- Children up to age 26 (includes birth children, stepchildren, legally-adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse);
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your medical plan to continue coverage past age 26.

Verification of dependent eligibility will be required upon enrollment.

Things to Consider

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria. Additional details can be found in the Eligible Dependents section of this guide.

Qualifying Life Events

When one of the following events occurs, you have 30 days from the date of the event to notify OD and/or request changes to your coverage:

- Change in your legal marital status (marriage, divorce or legal separation);
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent);
- Change in your spouse's employment status (resulting in a loss or gain of coverage);
- Change in your employment status from full-time to part-time, or part-time to full-time, resulting in a gain or loss of eligibility. NOTE: If you drop below 30 hours per week you may be able to extend your coverage due to Affordable Care Act requirements;
- Entitlement to Medicare or Medicaid;
- Eligibility for coverage through the Marketplace (during a Marketplace special or open enrollment period);
- Change in your address or location that may affect the coverage for which you are eligible.

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to OD.

Wastewater Operations Team Leader Richard Muntz with his wife on an excursion in Cabo San Lucas, Mexico.

Preparing to Enroll

GLWA provides its team members the best coverage possible. As a committed partner in your health, GLWA will be absorbing a significant amount of the costs. Your share of the contributions for medical, dental and vision benefits is deducted on a pre-tax basis, which lessens your tax liability. Please note that team member contributions for medical, dental and vision coverage vary depending on the level of coverage you select. In general, the more coverage you have, the higher your total contribution will be.

Keep in mind that you may select any combination of medical, dental and/or vision plan coverage categories. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible team member of GLWA, must elect coverage for yourself in order to elect any dependent coverage. Be sure to have the Social Security Numbers and birthdates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

Financial Services Management Professional Alicia Schwartz cutting her wedding cake with husband Geoff Schwartz.

You CANNOT change your benefit selections during the plan year unless you have a qualifying life event, such as marriage and/or the birth or adoption of a child.

OPEN ENROLLMENT CHECKLIST

You only have a small window of time to make changes that are effective for the entire plan year (unless you have a qualifying life event). To save time and money, here are some things you should check off of your to-do list before Open Enrollment begins.

1. Update your personal information.

If you've experienced a qualifying life event in the last year (moving, new baby, change in marital status, etc.), you may need to change your information. This seems like an obvious action to take, but failure to update your personal information could cost you in the long run.

2. Double check provider participation.

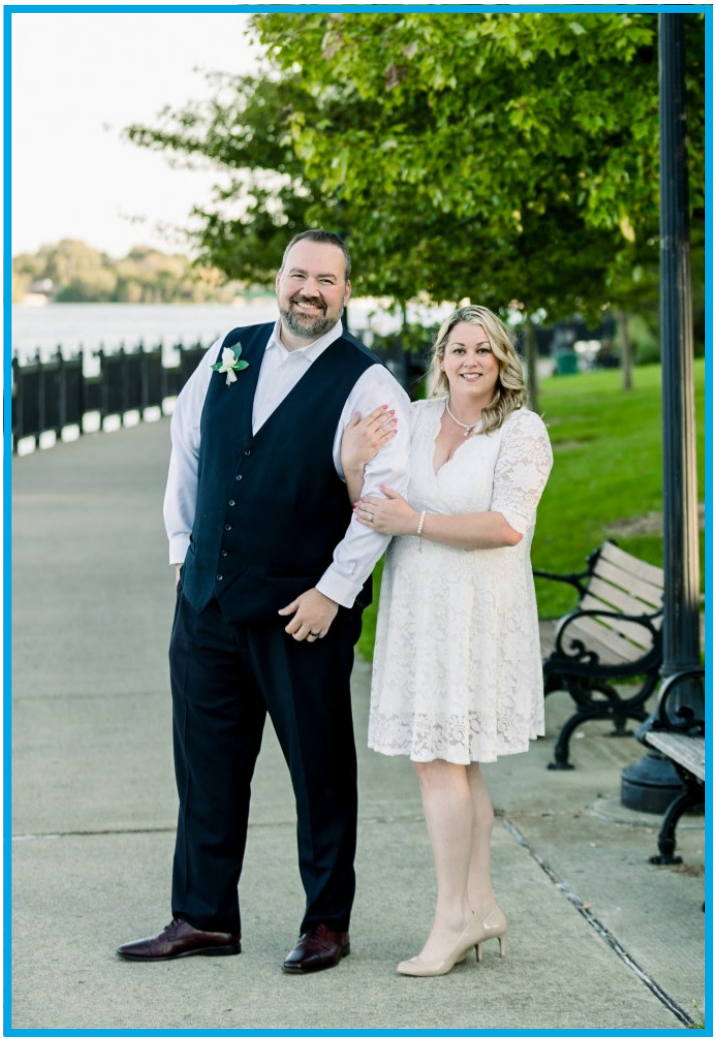
See HOW TO FIND A PROVIDER (page 7) to verify your doctor participates in the plan your are considering.

3. Review available plans' deductibles.

Changes to your deductible might trigger you to explore other plan options. If you're planning on having a baby or major surgery this year, think carefully about your out-of-pocket medical costs and deductible. Conversely, if you don't anticipate a great need for healthcare this year, perhaps you could switch to a plan with a higher deductible and lower premiums. Read on for more information about various plan deductibles later in the guide.

4. Consider your Flexible Spending Account (FSA).

Think about how much you plan to spend on healthcare in the coming year — this includes dental and vision services, prescriptions and more. Maybe this is the year to consider an FSA.



Public Affairs Specialist Jason Matthews with his bride Beth Matthews.

Information Technology Infrastructure Administrator Robin Keller and her son enjoying a day on Belleville Lake in 2019.

MEDICAL BENEFITS

Our medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers, as well as prescription medication. Medical benefits are offered through Blue Cross Blue Shield of Michigan and Health Alliance Plan (HAP). Choose the plan that best matches your needs. Please keep in mind that the option you elect will be in place for all of the 2021 plan year, unless you have a qualifying life event.

Medical Premiums

Premium contributions for medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your bi-weekly contributions.

How to Find a Provider

To see a current list of Blue Cross Blue Shield of Michigan network providers, visit www.bcbsm.com or call Customer Care at 877-790-2583 for assistance. To see a current list of HAP network providers, visit www.hap.org or call Customer Care at 800-422-4641 for assistance.

Medical Plan Summary

The chart on the next page gives a summary of the 2021 medical coverage provided by Blue Cross Blue Shield of Michigan and HAP. All covered services are subject to medical necessity, as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

Urgent Care Centers vs. Freestanding Emergency Rooms (ER)

Freestanding emergency rooms may look a lot like urgent care centers, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns rather than an ER could save you hundreds of dollars.

Telemedicine

Telemedicine provides all GLWA team members and their families with convenient 24/7 access to a doctor for minor medical illnesses via phone, online video or mobile app. Telemedicine includes access to behavioral health clinicians or psychiatrists to help work through different challenges such as anxiety, depression and grief. You will only have a $10 co-pay for Telemedicine services.

Omada Diabetes Prevention

Omada is a program that helps people with obesity-related chronic disease develop healthy habits that last. It aims to help with the prevention of diabetes. Qualified team members will receive a digital scale, dedicated coaching, and other interactive training to prevent the onset of diabetes.

Livongo Diabetes Management

Livongo is a program that works with people who have previously been diagnosed with diabetes manage their condition. Program participants receive a blood glucose meter, certified diabetes educators on call 24/7/365 for live interventions during acute events and for ongoing support, and unlimited supplies (strips and lancets) shipped directly to you.

Take advantage of preventive care offered by an in-network physician. This will save you time and money in the long run!

Pumba Dillon (Financial Services Management Professional Nick Dillon and Public Affairs Management Professional Stephanie Dillon's dog), prepares for the anticipated arrival of their firstborn child in August 2020.

	BCBSM COMMUNITY BLUE PPO PLAN		HAP HMO PLAN
BI-WEEKLY CONTRIBUTIONS			
TEAM MEMBER ONLY	$63.61		$64.07
TEAM MEMBER + 1	$133.58		$134.54
TEAM MEMBER + 2 OR MORE	$178.11		$179.38

	BCBSM COMMUNITY BLUE PPO PLAN		HAP HMO PLAN
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
CALENDAR YEAR DEDUCTIBLE			
INDIVIDUAL	$750	$1,500	$750
FAMILY	$1,500	$3,000	$1,500
COINSURANCE (PLAN PAYS)	80%*	60%*	80%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)			
INDIVIDUAL	$6,350	$12,700	$6,350
FAMILY	$12,700	$25,400	$12,700
COINSURANCE OUT-OF-POCKET MAXIMUM			
INDIVIDUAL	$1,500	$4,500	$1,500
FAMILY	$3,000	$9,000	$4,500
COPAYS/COINSURANCE			
PREVENTIVE CARE	100%	Not Covered	100%
PRIMARY CARE VISIT	$25 copay	60%*	$25 copay
TELEMEDICINE VISIT	$10 copay		$10
SPECIALIST VISIT	$25 copay	60%*	$25
DIAGNOSTIC SERVICES	80%*	60%*	80%*
URGENT CARE	$25 copay	60%*	$25
EMERGENCY ROOM	$100 copay	$100 copay	$100 copay

*After Deductible

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount.

There are no pricing standards for healthcare so charges for medical services can vary greatly — even for the same procedure, in the same area, within the same network.

PREVENTIVE CARE

Did you know that most health plans must cover a set of preventive services — such as shots and screening tests — at no cost to you? Work with your Primary Care Physician to stay up-to-date on preventive services — identifying and treating illnesses early will save you time and money, and promote a healthy lifestyle in the long run!

Any screening test done in order to catch a disease early is considered a preventive service. Due to the U.S. Patient Protection and Affordable Care Act (ACA), many services, screenings and supplies are paid at 100% including, but not limited to, the following:

- Wellness visits, yearly physicals and standard immunizations (like the flu shot);
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and Type 2 diabetes;
- Pediatric screenings for hearing, vision, obesity, depression, autism and developmental disorders;
- Anemia screenings, breastfeeding support and breastfeeding pumps for pregnant and nursing women;
- Iron supplements (for children ages 6 to 12 months at risk for anemia).

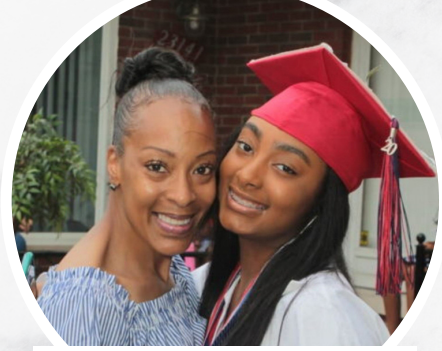
Key Things to Remember

- Many preventive care services and tests are covered at 100%. You can verify covered services by contacting your carrier's customer service line.
- Think of preventive care visits as routine check-ups. Things that may occur during a preventive visit include immunizations, blood pressure and cholesterol measurement, diabetes screening, or counseling on healthy weight.
- Diagnostic care to identify potential health risks are covered according to plan benefits, even if recommended or done during a preventive care visit.
- If your physician finds a specific health risk or new medical condition during your appointment, your doctor may bill those services as diagnostic medicine. These types of diagnostic services may result in out-of-pocket costs for you (i.e., deductibles, coinsurance, or copayments) because they are no longer considered preventive care.

To see what preventive services are available to you at no cost, contact your selected carrier's customer service line. See IMPORTANT CONTACTS on page 27.

Wastewater Operations Team Leader Erica Moore with her son, Cyrus Hallum III.

Water Operations Office Support Specialist Davidson Okpaleke and Team Leader Tamika Winston help "Pink Out the Plant" for Breast Cancer Awareness Month in October 2019



PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

For BCBSM members, your prescription drug program is coordinated through CVS Caremark. You will have two ID cards, one for BCBSM medical care and one for CVS Caremark to fill prescriptions. You may find information on your pharmacy benefits and search network pharmacies by logging on to www.caremark.com or by calling 800-678-0382.

For HAP members, your prescription drug program is coordinated through HAP. You will have one ID card for both medical care and prescriptions. You may find information on your pharmacy benefits and search network pharmacies by logging on to www.hap.org or by calling 800-422-4641.

Your cost is determined by the tier assigned to the prescription drug product. All products on the list are assigned as generic, preferred, non-preferred or specialty.

	BCBSM COMMUNITY BLUE PPO PLAN	HAP HMO PLAN
	IN-NETWORK ONLY	IN-NETWORK ONLY
RETAIL RX (30-DAY SUPPLY)		
GENERIC	$10	$10
PREFERRED	$35	$35
NON-PREFERRED	$50	$50
MAIL ORDER RX (90-DAY SUPPLY)		
GENERIC	$20	$20
PREFERRED	$70	$70
NON-PREFERRED	$100	$100

Financial Services Analyst Nadine Hampton and her daughter, N'jah Amir Brooks celebrating her high school graduation.

Industrial Waste Control Engineer Thomas Thomas with his family in Traverse City.

Q & A: GENERIC DRUGS

What is a Generic Drug?

Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts.

Are Generic Drugs as Effective as Brand-name Drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

What Standards do Generic Drugs have to Meet?

Health professionals and consumers can be assured that FDA approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

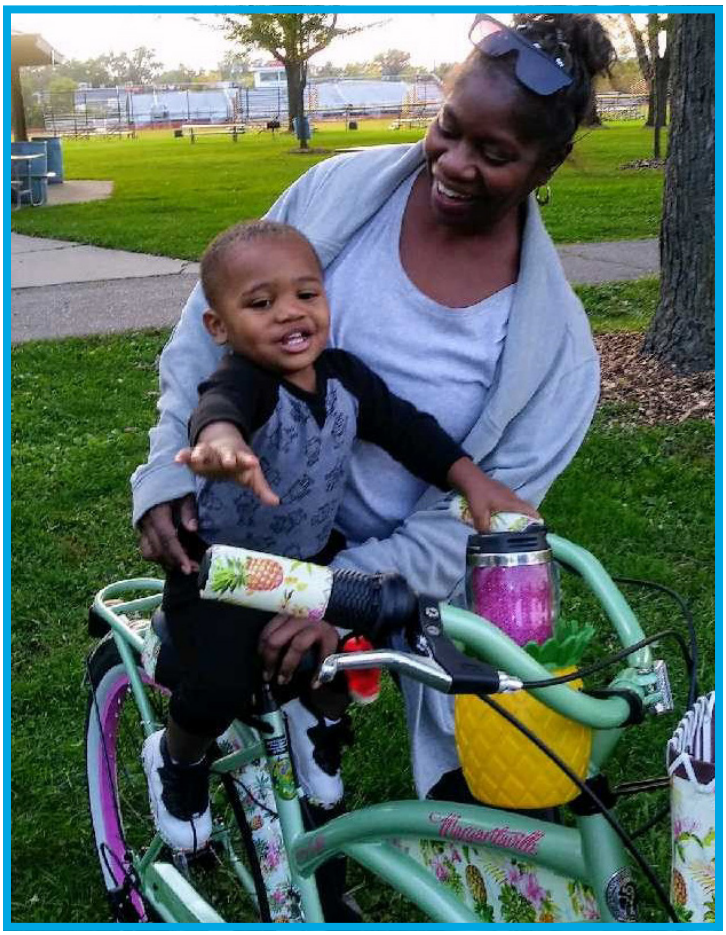
- Contain the same active ingredients as the innovator drug (inactive ingredients may vary);
- Be identical in strength, dosage form, and route of administration;
- Have the same use indications;
- Be bioequivalent;
- Meet the same batch requirements for identity, strength, purity and quality;
- Be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products.

Are Generic Drugs that Much Cheaper than Brand-name Medications?

Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a Generic Equivalent for My Brand-name Drug?

To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov to view a catalog of FDA-approved drug products, as well as drug labeling information.



Information Technology Applications Analyst Jennifer Payne and her son, Kyle O'Brien enjoying a family dinner.

Financial Services Management Professional Doretta Catchings with her grandson, Terry Catchings III.

DENTAL BENEFITS

NEW FOR 2021!
Dental coverage has *moved* from BCBSM to Delta Dental.

Why the change – To resolve increasing number of issues related to claims processing and dependents dropping from the plan in error.

Our dental benefits will remain the same – Our annual maximum benefit per person remains $1,000. Preventive care will remain covered outside of the $1,000 annual benefit maximum, so that you have the full $1,000 available for other dental services.

Network Dentists

If you choose to use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Delta Dental at www.deltadentalmi.com or call 800-524-0149.

Dental Premiums

Premium contributions for dental will be deducted from your paycheck on a pre-tax basis.

Dental Plan Summary

Dental plan benefits are available to you on a voluntary basis. The chart below gives a summary of the 2021 dental coverage provided by Delta Dental. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

DELTA DENTAL PPO PLAN

	BI-WEEKLY CONTRIBUTIONS	
TEAM MEMBER ONLY	$2.50	
TEAM MEMBER + 1	$4.99	
TEAM MEMBER + 2 OR MORE	$8.74	
	DELTA PPO AND PREMIER IN NETWORK	**DELTA OUT OF NETWORK**
	CALENDAR YEAR DEDUCTIBLE	
INDIVIDUAL	None	None
FAMILY	None	None
	CALENDAR YEAR MAXIMUM	
PER PERSON	Combined $1,000 per member per calendar year	Combined $1,000 per member per calendar year
	Note: Preventive (Class I) Services do not apply to the calendar year maximum	
	COVERED SERVICES	
PREVENTIVE SERVICES (CLASS I)	100%	50%
BASIC SERVICES (CLASS II)	80%	50%
MAJOR SERVICES (CLASS III)	50%	50%
ORTHODONTICS (CLASS IV)	50%	50%
ORTHODONTIC LIFETIME MAXIMUM	Combined $1,000 per member	

As many as 120 systemic diseases can be visible in your mouth. Regular checkups can reveal the signs of diseases before they even cross your mind.

Field Services Office Support Specialist Tracy Reynolds with her husband, Dion, grandson, KJ, and granddaughter, Quiynn.

VISION BENEFITS

Even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, GLWA offers a comprehensive vision benefit provided by Heritage Vision.

Vision Premiums & Plan Summary

Premium contributions for vision will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your bi-weekly premium. The chart below gives a summary of the 2021 vision coverage provided by Heritage Vision.

You may visit in-network providers outside of Heritage Retail locations. This means that team members (on both core and buy-up plans) no longer need to visit a Heritage Retail location to receive their benefits. Visit www.heritagevisionplans.com to identify eligible providers. NOTE: The Core plan uses the Select network, which is focused on Southeast Michigan, the Buy-Up plan uses the National network.

	CORE PLAN		BUY-UP PLAN	
BI-WEEKLY CONTRIBUTIONS				
TEAM MEMBER ONLY	$0.51		$1.52	
TEAM MEMBER + 1	$0.51		$3.71	
TEAM MEMBER + 2 OR MORE	$0.51		$7.22	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
COVERED MATERIALS				
LENSES				
SINGLE VISION LENSES	100% covered	Up to $30	100%	Reimbursed up to $30
BIFOCAL LENSES	100% covered	Up to $40	100%	Reimbursed up to $40
TRIFOCAL LENSES	100% covered	Up to $50	100%	Reimbursed up to $50
FRAMES				
RETAIL FRAME EQUIVALENT	$100 retail allowance; member responsible for amount over $100	Up to $35	$130 allowance, 20% off remaining balance	Reimbursed up to $45
CONTACT LENSES				
ELECTIVE	$45 retail allowance; member responsible for amount over $45	Up to $45	$100 allowance	Reimbursed up to $65
COPAYS				
EXAMINATION	100% covered	Up to $30	$5 copay	$5 copay
MATERIALS	No copay	No copay	$10 lens copay, $0 frame copay	$10 lens copay, $0 frame copay
COMBINED EXAM/CONTACT LENS FITTING	$45 allowance	Up to $30 allowance	$40 copay	N/A
BENEFIT FREQUENCY				
EXAMINATION	Once every 24 months		Once every 12 months	Once every 12 months
LENSES	Once every 24 months		Once every 12 months	Once every 12 months
FRAMES	Once every 24 months		Once every 12 months	Once every 12 months
CONTACTS (in lieu of Lenses and Frames)	Once every 24 months (glasses OR contacts, not both, in any 24 month consecutive period)		Once every 12 months	Once every 12 months

Financial Services Office Support Specialist Kaitlyn Butzin celebrating her wedding with her husband Ron Butzin.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for various out-of-pocket expenses.

Health Care Flexible Spending Account

You can contribute up to $2,750 for qualified medical expenses (deductibles, copays and coinsurance, for example) with bi-weekly pre-tax payroll deductions, which will reduce the amount of your taxable income and increase your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them, so you don't have to wait for reimbursement.

Please note: Over-the-counter (OTC) drugs are not eligible for reimbursement through an FSA without a doctor's prescription.

Dependent Care Flexible Spending Account

In addition to the Health Care FSA, you may opt to participate in the Dependent Care FSA as well — whether or not you elect any other benefits. The Dependent Care FSA allows you to set aside pre-tax funds to help pay for expenses associated with caring for elder or child dependents. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you are allowed to set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children younger than the age of 13 and claimed as a dependent on your federal income tax return, and dependents of any age who are incapable of caring for themselves and spends at least eight hours a day in your home.
- Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

Eligible Dependent Care Flexible Spending Account Expenses

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time.

Examples of eligible dependent care expenses include:

- In-Home Baby-Sitting Services (not by an individual you claim as a dependent);
- Care of a Preschool Child by a Licensed Nursery or Day Care Provider;
- Before- and After-School Care;
- Day Camp;
- In-House Dependent Day Care.

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the Flexible Spending Account programs. Please check with your tax advisor to determine if any exceptions apply to you.

How to Use the FSA Account

You can use your FSA debit card at locations such as doctor and dentist offices, pharmacies and vision service providers. The card cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The swipe transaction will be denied if you attempt to use the card at an ineligible location.

Once you incur an eligible expense, submit a claim form along with the required documentation. If you have a question about a reimbursement, contact Navia Benefits. Should you need to submit a receipt, you will receive an email or be mailed a receipt notification from Navia Benefits. You should always retain a receipt for your records.

- Up to $550 may be rolled over to the next plan year at the end of 2021 for Health Care FSAs.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event like marriage, divorce or birth of a child.

Your FSA money can cover the cost of going to a chiropractor or acupuncturist, if your insurance doesn't already cover it.

Public Affairs Specialist Curtis Burris-White celebrating his wedding anniversary with his wife LaToya Burris-White in Las Vegas.

GoNavia Commuter Benefits

Do you take public transit to work or pay for parking? Through GLWA's GoNavia Commuter Benefits, you can set aside tax-free money for eligible parking expenses or mass-transit fees.

Parking Reimbursement Account

You may set aside up to $270 a month — tax-free — in a Parking Reimbursement Account (PRA). Whenever you have parking expenses while you are at work, use the funds you've set aside in this account. The funds will be automatically deducted from your paycheck each pay period.

When you have a parking expense, submit a claim form to Navia Benefit Solutions, the PRA claim administrator. Any unused funds in your PRA will roll over each month; however, you must use your account balance within 180 days or you will lose those dollars. You may start or stop your account at any time.

Mass Transit Reimbursement

You may set aside up to $255 a month — tax-free — if you commute to work using mass transit. The funds will be automatically deducted from your paycheck each pay period. You can order a voucher or fare card online at www.naviabenefits.com to use for commuter fees. You may start or stop contributing to the account at any time. To find out more about commuter benefits, visit www.naviabenefits.com or call 800-669-3539.

Administrative and Compliance Services Professional Administrative Analyst Revia Bowie with her family at the Great Wolf Lodge.

SURVIVOR BENEFITS

It's not always easy to talk with your family about how they'll be provided for if you aren't around, but it's an important conversation to have with your loved ones. Survivor benefits provide financial assistance in an absence, and can help you plan for the unexpected. If you secure Life insurance now, chances are you can take comfort in knowing that those who depend on you will be provided for.

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

Life and AD&D benefits are essential to your family's financial security. As such, it is important to understand how your plan works and what benefits you will receive. Basic Life and AD&D benefits are provided to you as a part of your total compensation package. GLWA provides team members with Basic Life and AD&D insurance through Principal, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of a team member's benefits after death.

Your Basic Life and AD&D insurance benefit is 150% of your salary, up to $300,000.

If you are a full-time team member, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

Beneficiary Designation

A beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life and AD&D offered by GLWA. The portable insurance is subject to benefit reduction at age 65 and age 70. For a copy of the group policy, email Organizational Development at OD-All@glwater.org or call 313-964-9555. You receive benefit payment for a dependent's death under the Principal insurance.

Make sure your beneficiary designation is clear so there is no question as to your intentions, and remember to name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. If the beneficiary is not legally related, insert the word "Undefined" in the relationship field.

Please note that in most states, benefit payments cannot be made to a minor younger than 18. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name, and will earn interest until the minor reaches majority age at 18.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages. If you need assistance, contact Organizational Development at 313-964-9555 or your own legal counsel.

Long Term Care Insurance

You may supplement your current coverage by enrolling in the Chubb plan.

This coverage provides a life insurance benefit as well as Long Term Care benefits if you need them. As Life Insurance, the benefit protects your family with money that can be used any way they choose. For Long Term Care, if you become chronically ill, your policy will pay you 4% of your death benefit each month you receive Long Term Care for up to 75 months! You can use this money any way you choose, and your life insurance premiums will be waived.

Rates are based on your age at time of enrollment. You do not need to answer health questions if you are Team Member between the ages of 19 and 70, for a policy amount of up to $150,000 ($6,000/month for LTC). You must be actively at work for at least 30 hours per week to be eligible for this coverage. Spouses up to age 70 may apply for up to $75,000 of life insurance coverage ($3,000/month for LTC) with limited health questions.

Wastewater Operations Chemist Pamela Mittison with her twin daughters, (left, Gabrielle Hardin and right, Camille Hardin).

Life and AD&D Insurance

Eligible team members may purchase Voluntary Life and AD&D insurance for themselves and their families. Premiums are paid through payroll deductions.

	BASIC LIFE/AD&D
COVERAGE AMOUNT	150% of salary
WHO PAYS	GLWA
BENEFITS PAYABLE	If you die, lose a limb or suffer paralysis in an accident
MAXIMUM BENEFIT	$300,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
	VOLUNTARY EMPLOYEE LIFE
COVERAGE AMOUNT	Up to maximum benefit, in $10,000 increments
WHO PAYS	Team Member
BENEFITS PAYABLE	If you die while covered under the plan
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	$250,000
	VOLUNTARY SPOUSE LIFE
COVERAGE AMOUNT	Up to 100% of employee coverage, in $10,000 increments
WHO PAYS	Team Member
BENEFITS PAYABLE	If your dependent dies while covered under the plan
MAXIMUM BENEFIT	$250,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	$100,000
	VOLUNTARY CHILD LIFE
COVERAGE AMOUNT	Set amounts of $2,500 or $5,000 or $7,500 or $10,000. Children under 14 days of age receive $1,000 of coverage
WHO PAYS	Team Member
BENEFITS PAYABLE	If your dependent child dies while covered under the plan
MAXIMUM BENEFIT	100% of employee coverage or $10,000

VOLUNTARY LIFE INSURANCE

RATES/$1,000 (MONTHLY)

AGE (AS OF JANUARY 1, 2021)	TEAM MEMBER	AGE (AS OF JANUARY 1, 2021)	SPOUSE
To age 29	$0.078	To age 29	$0.078
30-34	$0.086	30-34	$0.086
35-39	$0.129	35-39	$0.129
40-44	$0.209	40-44	$0.209
45-49	$0.322	45-49	$0.322
50-54	$0.525	50-54	$0.525
55-59	$0.824	55-59	$0.824
60-64	$1.144	60-64	$1.144
65-69*	$2.112	65-69*	$2.112
70+*	$3.466	70+*	$3.466

* Benefits Subject To Age Reduction Schedule

VOLUNTARY CHILD LIFE INSURANCE

PREMIUM RATES – $0.20 MONTHLY

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Monthly Premium

INCOME PROTECTION

GLWA offers disability coverage to protect you against any debilitating injury. This insurance protects a portion of your income until you can return to work, or until you reach retirement age.

Short-Term Disability (STD) Insurance

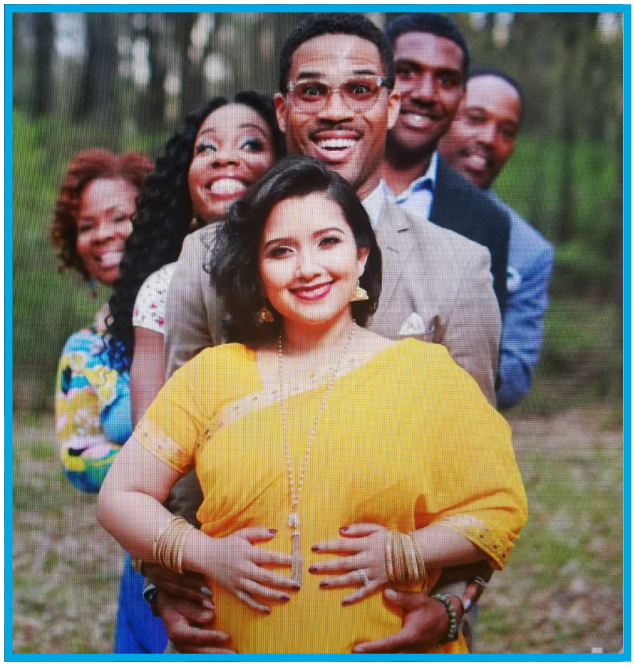
Short Term Disability (STD) insurance replaces 50% of your income if you become partially or totally disabled for a short period of time. Certain exclusions, along with any pre-existing condition limitations, may apply. Please contact OD for a copy of the plan document.

WEEKLY MAXIMUM BENEFIT	$2,500
WAITING PERIOD	14 days
MAXIMUM BENEFIT PERIOD	24 weeks

Long-Term Disability (LTD) Insurance

Long Term Disability (LTD) insurance replaces 50% of your income if you become partially or totally disabled for an extended period of time. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your plan documents for details or contact OD for specific benefits.

MONTHLY MAXIMUM BENEFIT	$10,000
WAITING PERIOD	180 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.



Wastewater Operations Team Leader Kenneth Paylor and his family.

RETIREMENT PLANS

It's never too early — or too late — to start planning for your retirement. Making contributions to a 401(k) account is the first step toward achieving financial security later in life. The GLWA Retirement Savings Plans provide you with the tools and flexibility you need to retire comfortably and securely. The comprehensive plan includes deferred compensation (457b), defined contribution (401a), retirement health care savings (RHS), and a Roth IRA plan.

Eligible team members can invest for retirement while receiving certain tax advantages. Administrative and record-keeping services for this plan are provided by ICMA-RC.

Eligibility

You are eligible to begin making pre-tax contribution with your first paycheck after your date of hire. Any deferred compensation changes made during the plan year will begin one to two paychecks after your deferral change has been submitted. You must also be at least 18 years of age to be eligible.

Deferred Compensation (457b)

The deferred contribution limit, which is set annually by the IRS, is $19,000 for 2021.

Catch-up Contributions To The 457b Plan

If you are or will be age 50 or older during this calendar year and you already contribute the maximum allowed to your 457b account, you may also make a "catch-up contribution." This additional deposit of funds accelerates your progress toward your retirement goals. The maximum catch-up contribution is $6,000 for 2021 — for a combined total contribution allowance of $25,000. Contact ICMA-RC for more details.

Changing or Stopping Your Contributions To The 457b Plan

You may change the amount of your contributions any time. All changes will become effective as soon as administratively feasible and will remain in effect until you modify them. You may also discontinue your contributions at any time. If you stop making contributions, you may start again at any time.

Making a Rollover to Your GLWA 457b Plan

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer or rollover that account into the plan any time. To initiate a rollover into your plan, contact ICMA-RC for details by logging in at www.icmarc.org or by calling 800-669-7400.

Investing in the 457b Plan

You decide how to invest the assets in your account. The GLWA 457b plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, contact ICMA-RC.

Defined contributions - Auto enrolled

GLWA deposits a contribution equal to six percent of your annual base pay into a 401a account in your name. Also, GLWA will match your 457b contribution, up to three percent, and deposit the match amount into your 401a account. Also, GLWA will match your biweekly 457b contribution, up to three percent, and biweekly deposit the match amount into your 401a account.

Retirement Health Care Savings Plan (RHS)

The RHS plan is co-funded by you and GLWA. Team members contribute $10 per pay. GLWA contributes $80 per pay.

VESTING SCHEDULE FOR 401A AND RHS PLANS	
YEARS OF SERVICE	**PERCENTAGE VESTED**
3	100%

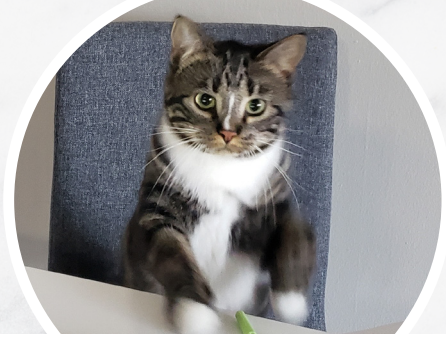
Payroll Deducted Roth IRA

A Roth IRA is a tax-advantaged savings vehicle that complement your retirement plan. Investments are tax-deferred and earnings may be withdrawn tax- and penalty-free if you have owned a Roth IRA for at least a five-year period, as defined by the IRS, and have a qualifying event, including age 59 1/2, a "first-time" home purchase, disability or death. Otherwise, ordinary income and penalty taxes may apply. (See IRS Publication 590.)

Contribute as little as $10 per pay period. The deferred post-tax annual contribution limit, which is set by the IRS, is $5,500 for 2021. Age 50 and older may make an additional $1,500 contribution. Enroll by visiting www.icmarc.org or by calling 800-669-7400.

Security and Integrity Critical Infrastructure Manager Walt Davis with his family on a cruise in 2016.

If you dip into your 457b account before age 59 1/2,you will pay a 10% early withdrawal penalty—in addition to income tax—on the amount.



ADDITIONAL BENEFITS

GLWA knows the value of well-rounded, balanced team members, which is why we offer a variety of additional benefits to help manage life's daily stresses.

Employee Assistance Program

GLWA cares about you and your family's total health management — mental, emotional and physical. For that reason, we provide an Employee Assistance Program (EAP) with Health Management Systems of America (HMSA), at no cost to you.

Whether you are interested in work/life resources, mental health assistance, or legal and financial advice, the EAP service can connect you and members of your household with a variety of professionals. With just one phone call, at any hour of the day or night, you can have access to helpful resources. The EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with GLWA. You may also access information, benefits, educational materials and more either by phone at 800-847-7240 or online at www.my-life-resource.com. (Company Username: hmsa Password: myresource)

The Program provides referrals to help with:

- Emotional Health and Well-Being;
- Alcohol or Drug Dependency;
- Marriage or Family Relationship Problems;
- Job Pressures;
- Stress, Anxiety, Depression;
- Grief and Loss;
- Financial or Legal Advice.

Additional Voluntary Benefits

Critical Illness Insurance can pay money directly to you when you're diagnosed with certain serious illnesses. If you apply during open enrollment, you can receive coverage without a health exam or medical questions. Coverage is portable, so you can take the coverage with you if you leave GLWA and you'll be billed at home. For more information or to enroll, submit your election in DayForce while completing the Open Enrollment process.

Accident Insurance is designed to pay a lump sum benefit directly to you for an accidental injury. For more information, visit www.unum.com or call 800-635-5597. To enroll, submit election in DayForce while completing Open Enrollment process.

Whole Life Insurance with Long-term Care Rider For more information, or to enroll, visit www.unum.com or call 800-635-5597.

Pet Insurance by Nationwide features 90% back on vet bills, one set price, regardless of the pet's age, and an optional wellness plan that includes spay/neuter, preventive dental cleaning and more. Just like all other pet insurers, Nationwide does not cover pre-existing conditions. However, extra features such as emergency boarding, lost pet advertising, a free VetHelpline and more are offered. Both plans have a low $250 annual deductible and a generous $7,500 maximum annual benefit. For more information, or to enroll, visit www.petinsurance.com/glwater or call 800-872-7387.

Honorary member of the Organizational Development team, Henry Kin (OD Office Support Specialist Zuzanna Kin's cat). Henry supports Zuzanna while she works from home during the coronavirus pandemic.

Organizational Development Human Resource Generalist Danyelle Davis and her husband on vacation in Puerto Rico.

GLOSSARY

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (for example, 20 percent) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20 percent would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

Copay – The fixed amount, as determined by your insurance plan, you pay for health care services received.

Deductible – The amount you owe for health care services before your health insurance or plan sponsor (employer) begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've met your $1,000 deductible for covered health care services. This deductible may not apply to all services, including preventive care.

Employee Contribution – The amount you pay for your insurance coverage.

Explanation of Benefits (EOB) – A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket health care costs. This means you'll save an amount equal to the taxes you would have paid on the money you set aside.

- **Health Care FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code. Please note that over-the-counter medications are not eligible for reimbursement without a doctor's prescription with the Health Care FSA.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before- or after-school programs, and child or elder daycare. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Network – A group of physicians, hospitals, and other health care providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide healthcare services at discounted rates.
- **Out-of-Network –** Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance company.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount. This limit does not include your premium, charges beyond the Reasonable & Customary, or health care your plan doesn't cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

Over-the-Counter (OTC) Medications – Medications made available without a prescription.

Prescription Medications – Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. The color or flavor of a generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic and often costly conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Because of the high cost of these specialty drugs, many insurers require that specific criteria be met before a drug is covered. These requirements often include:
  - Performing a prior authorization to request coverage of the medication;
  - Having a specific disease that the drug is FDA-approved to treat.

Security Officer William Sims enjoying a night out with his grandson.

- Having a history of trying and failing cheaper medications.
- Creating high out-of-pocket costs when purchasing the medication.
- Restricting what pharmacy can dispense these medications.

- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer team members to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The Usual and Customary amount sometimes is used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by health care reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

The General Council Team participating in GLWA's Annual Holiday Collection Drive for The Children's Center of Detroit.

Required Notices

IMPORTANT NOTICE FROM GREAT LAKES WATER AUTHORITY 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 Great Lakes Water Authority and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Great Lakes Water Authority has determined that the prescription drug coverage offered by the Great Lakes Water Authority Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go 63 continuous days or longer without "creditable" prescription drug coverage (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Great Lakes Water Authority Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Great Lakes Water Authority Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Great Lakes Water Authority Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Great Lakes Water Authority prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information, or call (313) 964-9826. 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 Great Lakes Water Authority changes. You also may request a copy.

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 whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2021

Name of Entity/Sender: The Great Lakes Water Authority

Contact—Position/Office: Organizational Development

Address: 735 Randolph
Detroit, MI 48226

Phone Number: (313) 964-5555

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

GREAT LAKES WATER AUTHORITY

IMPORTANT NOTICE

COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Great Lakes Water Authority that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

- Treatment: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- Payment: Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- Health care Operations: The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- Other Uses and Disclosures of Your PHI Not Requiring Authorization. The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- To the Plan Sponsor: The Plan may disclose PHI to the employers (such as Great Lakes Water Authority) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollment's, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.

- To the Plan's Service Providers: The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan

management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.

- Required by Law: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.

- For Public Health Activities: The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

- For Health Oversight Activities: The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- Relating to Decedents: The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

- For Research Purposes: In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

- To Avert Threat to Health or Safety: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

- For Specific Government Functions: The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- Uses and Disclosures Requiring Authorization: For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

- Uses and Disclosures Requiring You to Have an Opportunity to Object: The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- To Request Restrictions on Uses and Disclosures: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

- To Choose How the Plan Contacts You: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

- To Inspect and Copy Your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- To Request Amendment of Your PHI: If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- To Find Out What Disclosures Have Been Made: You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Organizational Development

(313) 964-5555

The effective date of this notice is: January 1, 2021.

GREAT LAKES WATER AUTHORITY EMPLOYEE HEALTH CARE PLAN

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 later 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 toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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:

Organizational Development

(313) 964-5555

* This notice is relevant for healthcare coverages subject to the HIPAA portability rules.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Great Lakes Water Authority Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Great Lakes Water Authority Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Policy Booklet or contact your Plan Administrator at:

Organizational Development

(313) 964-5555

IMPORTANT CONTACTS

COVERAGE	CONTACT
MEDICAL	Blue Cross Blue Shield of Michigan 877-704-2583 www.bcbsm.com Group #: 007041382-000 Health Alliance Plan 800-422-4641 www.hap.org Group #: 10004886-1000
PHARMACY	CVS Caremark 800-678-0382 www.caremark.com Group #: 1175 (Caremark only applies to BCBSM medical coverage)
DENTAL	Delta Dental of Michigan 800-524-0149 www.deltadentalmi.com
VISION	Heritage Vision 800-252-2053 www.heritagevisionplans.com Group #: 4116-01 and 4116-02
FLEXIBLE SPENDING ACCOUNTS	Navia Benefits 800-669-3539 www.naviabenefits.com
LIFE AND AD&D	Principal 800-245-1522 www.principal.com Group #: 1056205
DISABILITY	Principal 800-245-1522 Group #: R66077 www.principal.com
EMPLOYEE ASSISTANCE PROGRAM	Health Management Systems of America (HMSA) 800-847-7240 www.my-life-resource.com Company username: hmsa Password: myresource
CRITICAL ILLNESS, ACCIDENT INSURANCE, WHOLE LIFE WITH LTC RIDER	UNUM 800-635-5597 www.unum.com Critical Illness Policy #: 649386 Accident and Whole Life Policy #: R0760686
VOLUNTARY LIFE INSURANCE WITH LONG TERM CARE	Chubb 888-407-8175 www.getltci.com/glwa
PET INSURANCE	Nationwide 800-540-2016 www.nationwide.com/glwater
RETIREMENT SAVINGS	ICMA-RC 800-669-7400 www.icmarc.org
GLWA ORGANIZATIONAL DEVELOPMENT	735 Randolph Detroit, MI 48226 313-964-9555 OD-All@glwater.org

GO MOBILE!

Directly access GLWA's benefits information on the go with the **Lockton BenefitLink Mobile App**. You'll find benefits contact information, Open Enrollment push notifications, Lockton's digital Lifestyle Benefits newsletter and more!

Lockton BenefitLink
Username: Onewater
Password: Oneteam

Download on the App Store

GET IT ON Google Play

Water and Field Services Field Technicians Curtis Carter and Kevin Brennan work safely to inspect and restore fire hydrants.

NOTES

GLWA
Great Lakes Water Authority