

Open 2026 GUIDE Enrollment



SCADA Technician Philip William with his wife Jini, son Alfred, and daughter Allison.





Jordie Kramer
Chief Organizational Development Officer
735 Randolph Street, 20th Floor
Detroit, Michigan 48226
Jordie.kramer@glwater.org

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Dear Great Lakes Water Authority team member,

You're a valued team member, and your health and well-being are important to us. Each year we provide an open enrollment guide that outlines our comprehensive benefit offerings, eligibility requirements, and effective coverage dates. We encourage you to take the time to review the guide as you consider your benefit elections for 2026. It also includes the Summary of Benefit Coverage (SBC), which provides examples of how the medical plans work.

Open Enrollment will run from October 30 to November 14, 2025.

New this year...

- Symetra will be the **NEW** provider for life insurance, disability and FMLA administration
- The annual limit for the dependent day care flexible spending account increased to \$7,500
- Voluntary benefit plan updates: increased benefit levels and lower cost for the UNUM accident plan and the addition of the UNUM hospital insurance plan

For team members that select health care coverage through GLWA, the 2026 per pay deductions are included in this guide. GLWA contributes 80% of the total cost for health care coverage, and team members contribute the remaining 20%. This year we are continuing with a "PASSIVE ENROLLMENT" which means:

- **NO ACTION REQUIRED - if you do not want to make a change** to your medical, dental or vision plans, **AND** you are not enrolling in a flexible spending account (Navia FSA) for 2026.
- **ACTION REQUIRED - if you would like to make a change** to medical, dental, vision, voluntary life insurance, accident, or critical illness **OR** you are enrolling in a flexible spending account (Navia FSA) for health care or dependent care.

Wellness Fairs will be held at the following locations – these are great opportunities for you to ask questions regarding open enrollment and your benefit selections. A flu vaccine clinic, pharmacogenomic testing (Exact Meds), as well as cardiovascular screening (AngioScreen) will also be available:

November 4 (WRRF) November 5 (CSF) November 6 (WWP)

Additional open enrollment information is available on the One Water Connect Virtual Open Enrollment page. You may also contact the One Water Wellness Team at OneWaterWellness@glwater.org.

Jordie Kramer
Chief Organizational Development Officer

Note: This guide is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits.

www.glwater.org



Supporting Your Personal Resiliency and Well-Being



Have questions or concerns?

Email the One Water Wellness Team at onewaterwellness@glwater.org.

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Budget Management Professional Maitrak Trivedi and his family.



Life Cycle Project Manager Paul Ransom with his wife and kids on their annual family ski trip vacation at Crystal Mountain Resort.

Eligibility and Enrollment

Full-time team members are eligible to participate in GLWA's medical, dental, vision, life insurance, and flexible spending account plans.

When does coverage begin?

Coverage is effective January 1, 2026. Due to IRS regulations, once you have made your choices for the 2026 plan year, you won't be able to change your benefits until the next enrollment period unless you experience a qualifying life event.

Things to consider when determining your benefit needs

- Do you have benefit coverage through another source?
- Are you covered through your spouse's benefits?
- Did you get married, divorced, have a baby, adopt a child or become the legal guardian of a child?

Eligible dependents

Dependents eligible for coverage in the GLWA benefits plans include:

- Your legal spouse.
 - Are you covered through another plan? Coverage can be through a spouse, parent, or other source.
- Dependent children
 - Children by birth or legal adoption may be covered up to age 26 (includes biological 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) through December 31 of the year that they reach age 26.
 - Disabled 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.
- Under the Patient Protection Affordable Care Act (PPACA), your child may remain on your medical coverage until 26.
- The maximum age for a child on your dental and vision coverage is 19. Without supporting documentation, coverage will terminate at the end of the month when your child reaches their 19th birthday. Children enrolled in college full time can stay on dental and vision until age 25 with a current semester schedule emailed to onewaterwellness@glwater.org.

Important: Verification of dependent eligibility will begin after open enrollment has been completed.



Emergency Preparedness Professional Administrative Analyst Tracy Reynolds putting together a puzzle with her granddaughter Ivey

Qualifying life events

When one of the following events occurs, you have 30 days from the date of the event to notify the One Water Wellness team to request change to your coverage:

- Change in your legal marital status (marriage, divorce or legal separation).
- Change in the number of your dependents (birth, adoption, death, or if a child is no longer an eligible dependent).
- Change in your spouse's employment status that resulted in a loss or gain of insurance coverage.
- Change in your employment status from full-time to part-time, or part-time to full-time, resulting in gain or loss of insurance coverage.
- Entitlement to Medicare or Medicaid.
- Eligibility for coverage through the Marketplace (during a Marketplace special or Open Enrollment period).

The One Water Wellness team is available to answer your questions regarding qualifying life events and how they may impact your coverage.

Preparing to enroll

GLWA is a committed partner in your health, and absorbs a significant amount of the costs (80%). 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 categories. For example, you could select medical 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 number and birth dates for any eligible dependent(s) you plan to enroll. You cannot enroll your dependent(s) without this information.

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.



Organizational Development Business Project Advisor Cheryl Yapo and her children Sonni and Sam Morais for their annual Mother's Day pictures at Cranbrook

Open Enrollment Checklist

Here are some things you should check off 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.), check and verify that your information is correct in Workday.

2. Double-check provider participation.

See how to find a provider (page 9) to verify your doctor participates in the plan you are considering.

3. Review deductibles for available plans.

Changes to your deductible might cause you to explore other plan options. If you're planning on having a baby or some other major procedure this year, consider what your out-of-pocket medical costs and deductible may be.

4. Prepare

If adding dependents to coverage, have Social Security numbers and required documentation (such as marriage license, birth certificate, or, verification of birth) available to upload into Workday.

5. 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. See page 17 for more information.



Electrical Instrumentation Control Technician David Darrow with his wife Shannon and their children Bradley and Jessica visiting the Ohio Caverns



Water Quality Chemist Pamela Mittison with her husband Patrick

Medical

Our medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers. Medical benefits are offered through Blue Cross Blue Shield of Michigan (BCBSM) and Health Alliance Plan (HAP). Choose the plan that best matches your needs.

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

Visit Blue Cross Blue Shield of Michigan at bcbsm.com or call Customer Care at 877-790-2583 for assistance.

Visit Health Alliance Plan at hap.org or call Customer Care at 800-422-4641 for assistance.

Medical plan summary

See page 10. Please be aware that all out-of-network services are subject to Reason and Customary (R & C) limitations.

Urgent care centers vs. freestanding emergency rooms (ERs)

Freestanding emergency rooms may look and feel a lot like an urgent care center, but the costs and services can be drastically different. Consider an urgent care center an extension of your primary care physician, for those unpredictable non-life-threatening emergencies that need medical attention. Freestanding emergency room should be used for health conditions that require a high level of care. Become familiar with the urgent care centers in your area.

Teledoc

Services will be expanded to include support for the following conditions:

- Prediabetes
- Diabetes management
- Hypertension
- Weight management
- Mental health

Best of all, it's at no cost to you — 100% covered by GLWA.

Hinge Health

Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll receive physical therapy tailored to your condition and a personal care team of experts. Best of all, it's at no cost to you — 100% covered by GLWA.

Exact Meds

Pharmacogenomic testing to help you know ahead of time whether a prescription drug is likely to benefit you and be safe for you to take. It is a cheek swab test you can complete at home. Your genes make the single largest difference in your response to medications and Exact Meds makes truly personalized prescribing possible. With a simple test and a thorough consultation with a licensed pharmacist, your doctor can finally tailor your medications exactly for you. The benefits to you are:

- Get healthier faster
- Avoid serious adverse reactions
- Save money on healthcare expenses
- Reduce the number of pills you take

Best of all, the test is at no cost to you — 100% covered by GLWA.

BCBSM COMMUNITY BLUE PPO PLAN

HAP HMO PLAN

	BI-WEEKLY CONTRIBUTIONS	
TEAM MEMBER ONLY	\$75.09	\$85.81
TEAM MEMBER + 1	\$157.70	\$180.21
TEAM MEMBER + 2 OR MORE	\$210.21	\$240.28

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	Covered 100%	Not covered	100%
PRIMARY CARE VISIT	\$25 copay	60%*	\$25 copay
TELEMEDICINE VISIT	\$10 copay		\$10
SPECIALIST VISIT	\$25 copay	60%*	\$25
DIAGNOSTIC, LAB & PHYSICAL THERAPY SERVICES	Covered 100%	100%	100%
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

GLWA medical benefits cover preventative services-such as shots and screening tests-at no cost to you. Work with your primary care physician to stay up to date on preventative services. Identifying and treating illnesses early will save you time and money and support a healthy lifestyle in the long run.

Any screening test done to diagnose a disease early is considered a preventative 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 checkups. Things that may occur during a preventive visit include immunizations, blood pressure and cholesterol measurement, diabetes screening or counseling on healthy weight.
- Diagnostic care and laboratory tests to identify potential health risks will now be covered 100%, 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 will now be covered at 100%.

To see what preventive and diagnostic services are available to you at no cost, contact your selected carrier's customer service line. See important contacts on page 40.



Facilities Management Professional Constance Williams-Spann and her husband Michael in Myrtle Beach, SC.



Facilities Management Professional Douglas Atkinson and his son AJ along Lake St. Clair

Pharmacy Benefits

Prescription drug coverage for the BCBSM medical plan

For BCBSM members, your prescription drug program is coordinated through CVS Caremark. **You will have two ID cards, one BCBSM ID card for medical care, and one CVS Caremark ID card for prescriptions.** You may find information on your pharmacy benefits and search network pharmacies by logging on to 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 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/ CVS CAREMARK	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 Reporting Manager Steve Hoover's sons Brendan and Patryk after catching a largemouth bass at Kibby Creek Campground in Ludington



Financial Reporting Manager Steve Hoover and his sons Brendan and Patryk in Ludington North Breakwater Lighthouse

Q&A: Generic Drugs

What is a generic drug?

Generic drugs are approved as meeting the same standards of safety, purity, strength, and effectiveness as the brand-name drug.

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.

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.



Fleet Operations Management Professional Lawrence Feagin and his wife Kimberly at Table Mountain in Cape Town, South Africa

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.

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 fda.gov to view a catalog of FDA-approved drug products as well as drug labeling information.



Fleet Operations Management Professional Lawrence Feagin and his wife Kimberly enjoying GOLD Restaurant in Cape Town, South Africa

Dental Benefits

GLWA offers an affordable plan option from Delta Dental of Michigan for routine care and beyond. The plan is designed to promote regular dental visits and good oral health, a key part of your overall wellness. Your dental election is separate from your medical plan election, meaning you can elect dental coverage even if you waive medical coverage. Your covered dependents will be enrolled in the same coverage you enroll in.

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 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 2026 dental coverage provided by Delta Dental.

DELTA DENTAL PPO PLAN

BI-WEEKLY CONTRIBUTIONS		
TEAM MEMBER ONLY		\$3.45
TEAM MEMBER + 1		\$6.90
TEAM MEMBER + 2 OR MORE		\$12.07

	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.

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 2026 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 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.



Fleet Team Management Professional David Banka and his wife Patricia at the Lone Pine Koala Sanctuary in Queensland, Australia



IT Project Manager Eddie Haidar and his son Dean, wife Marwa and daughter Layla after winning 1st Place in the Gus Macker 3x3 basketball tournament

HERITAGE VISION PLAN

CORE PLAN

BUY-UP PLAN

BI-WEEKLY CONTRIBUTIONS

TEAM MEMBER ONLY	\$0.51	\$1.38
TEAM MEMBER + 1	\$0.51	\$3.65
TEAM MEMBER + 2 OR MORE	\$0.51	\$7.04

IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
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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
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CONTACT LENSES

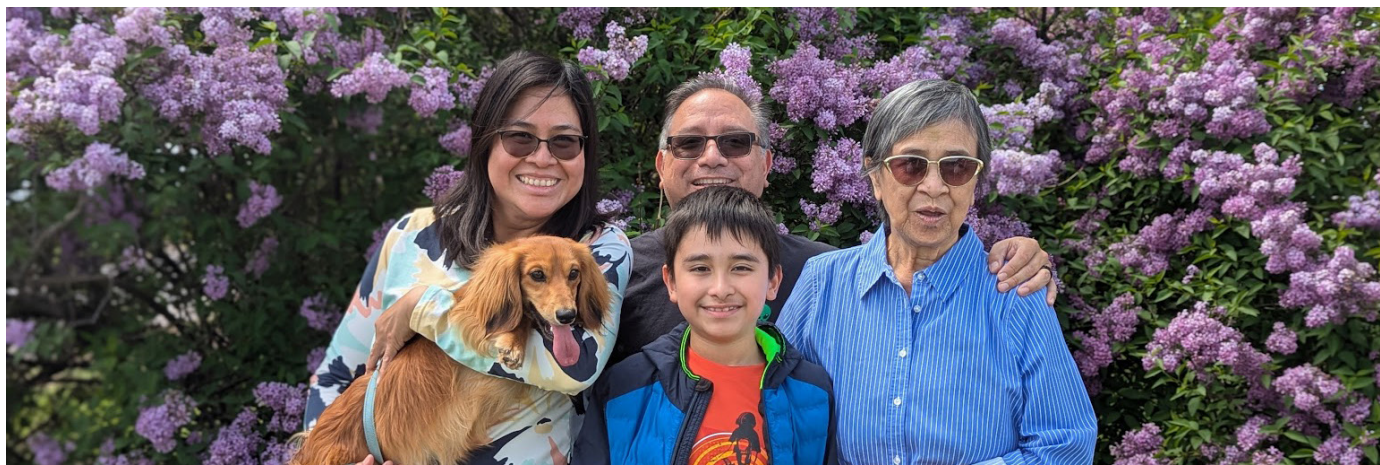
ELECTIVE	\$45 retail allowance; member responsible for amount over \$45	Up to \$45	\$100 allowance	Reimbursed up to \$65
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COPAYS

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



IT Security and Risk Director Frank Garcia and his family at Belle Isle, including his grandmother, wife, son and their long-haired dachshund Iceman

Flexible Spending Account (FSA)

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

Important IRS Information

The Internal Revenue Service (IRS) will release the 2026 annual limits in early November.

In order to elect the Health Care FSA:

- You cannot be enrolled in the high deductible health plan (HDHP)
- You may not change your Health Care FSA during the plan year unless you experience a life event such as: marriage, birth, adoption, etc.
- IRS regulations do not allow exceptions if you miss the enrollment deadline, regardless of your reason.
- The IRS regulates qualified expenses and dependents, refer to IRS Publication 502 and IRS publication 503 at [irs.gov](https://www.irs.gov).
- Consult your tax preparer, tax attorney, or accountant if you have any questions regarding your specific tax situation.
- IRS guidelines require you to retain receipts for any eligible expense for which you receive reimbursement.



Procurement Professional Administrative Assistant Kate Butzin and her husband at Tulip Fest



Water Operating Services Team Leader Jon Aferi and his wife Mallory and daughters Olivia and Grace enjoying a Tigers game.

Great Lakes Water Authority Benefits Guide

	HEALTH CARE FSA	DEPENDENT CARE FSA	COMMUTER BENEFIT
Purpose	Allows you to use pre-tax dollars to pay for qualified medical, prescription, dental and vision expenses.	Allows you to use pre-tax dollars to pay for qualified medical, prescription, dental and vision expenses.	Allows you to use pre-tax dollars for transit to work or pay for parking.
Amount you can contribute	Contribute between \$100 — \$3,300 for the 2026 plan year. You can NOT change your election unless you have a qualifying life event.	Contribute between \$100 — \$7,500 for the 2026 plan year. You can NOT change your election unless you have a qualifying life event.	Contribute up to \$325 monthly for the 2026 plan year. You can adjust your election as your needs change throughout the year.
Examples of Eligible Expenses	<ul style="list-style-type: none"> ■ Deductibles/copays/ prescriptions. ■ Contact lenses/eyeglasses/ LASIK. ■ Dental treatments/ orthodontia. ■ Menstrual care. ■ Certain over-the-counter items. Visit naviabenefits.com for a complete list of qualified expenses.	<ul style="list-style-type: none"> ■ Preschool. ■ Before/after school care. ■ Summer camp. ■ Care for a dependent in the team members' home or the home of the provider. Visit naviabenefits.com for a complete list of qualified expenses	Eligible transit expenses: <ul style="list-style-type: none"> ■ Bus ■ Vanpooling fees Eligible parking expenses: <ul style="list-style-type: none"> ■ Metered parking ■ Daily/monthly fees for parking lots ■ Park n' ride lots ■ Parking at mass transit facilities
Eligible Dependents	<ul style="list-style-type: none"> ■ Child or adopted child that you claim as a tax dependent. ■ Legal spouse. ■ Qualified relative you provided over half of their support. Certain rules apply, refer to IRS publication 502 for specific details.	<ul style="list-style-type: none"> ■ Dependent children under the age of 13 and whom you claim as a tax exemption on your federal tax return. ■ Qualified relative unable to care for themselves. Certain rules apply, refer to IRS publication 503 for specific details.	N/A
Fund Availability	Your entire annual election amount is available for payment on January 1st even if you have not contributed the full amount.	Your funds are available as contributions are made through your payroll deductions.	Your funds are available as contributions are made through your payroll deductions.
Rollover	Up to \$660 may be rolled over to the next plan year for health care.	At the end of each year, all balances are forfeited.	



Procurement Professional Administrative Assistant Kate Butzin and her family

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 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

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 The Hartford, 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.

For a copy of the group policy, email Organizational Development at onewaterwellness@glwater.org or call 313-964-9555.

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. Your beneficiary receives death benefit payment from The Hartford 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.

If you need assistance, contact Organizational Development at 313-964-9555 or your own legal counsel.



Public Affairs Management Professional Debbie Frazier and her daughter Dominique, son Dior and grandson Drew



Public Affairs Management Professional Debbie Frazier and her grandson Drew

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 the time of enrollment. You do not need to answer health questions if you are a 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 full time to be an eligible Team Member 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.

Voluntary life insurance

Eligible team members may purchase voluntary life and AD&D insurance for themselves and their families. Premiums are paid through payroll deductions. This portable insurance is subject to benefit reduction at age 65 and age 70.

BASIC LIFE/AD&D	
COVERAGE AMOUNT	1.5% 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, 2026)	TEAM MEMBER	AGE (AS OF JANUARY 1, 2026)	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 — \$0.50 MONTHLY

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$$\begin{array}{ccccccc}
 \$ & & \div 1,000 = & \$ & \times \text{Age Based Rate} = & \$ & \\
 \text{Benefit Elected} & & & & & \text{Monthly Premium} &
 \end{array}$$



Public Affairs Management Professional Jason Matthews with his wife Beth and son Landon



Public Affairs Management Professional Mallorie Stiger and her son Aiden

Income Protection

GLWA offers short-term and long-term disability coverage.

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.



Public Affairs Creative Services Manager Curtis Burris-White and his extended family



SCADA Technician Douglas Higgins enjoying a Lions game with his son Hunter

Retirement Plans

It's never too early — or too late — to start planning for your retirement. Making contributions to a retirement 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 MissionSquare Retirement.

Deferred Compensation (Your money)

- 457b — Your pre-tax and post-tax contributions
- Roth IRA — Your post-tax contributions
- Eligibility — Immediately

Defined Contribution, 401a (GLWA gives)

- GLWA's 6% of pay contribution (DC-retirement)
- GLWA's match on your 457b contribution, up to 3%
- Eligibility — Immediately

457b	3%
401a	6%
457b ER Match	3%
	12%

Setup your online access at www.missionsq.org

Retirement Health Care Savings Plan

- Co-funded by you and GLWA.
- Split — Every Team Member (\$10 per pay). GLWA (\$80 per pay)
- Eligibility — Immediately

Make elections: Workday

Select your investment options by logging into your MissionSquare Retirement account at missionsq.org

Full-time eligible team members are automatically enrolled in the plan. GLWA will withhold a percentage of your pay on a pre-tax basis. This is a mandatory, non-elective contribution. In addition, GLWA will contribute a mandatory non-elective contribution made to the plan on your behalf.

Note: Team members must be at least 18 years of age to contribute to any plan offering.



SCADA Technician Philip William with his wife Jini, son Alfred and daughter Allison



Professional Administrative Analyst Diane Luke enjoying a vacation

Deferred compensation

A 457 (b) supplemental voluntary plan that allows you to save for retirement with pre-tax and/or after-tax (Roth 457b) deductions from your paycheck. All full time eligible team members are eligible to enroll in this plan.

The deferred contribution limit, which is set annually by the IRS, is \$23,5000 in 2025. GLWA will match your 457b contribution, up to 3%, dollar for dollar, for each pay date that you make a 457b contribution. This match is deposited into your 401a plan account.

IMPORTANT: The Internal Revenue Service (IRS) will release the 2026 annual limits in early November.

Catch-up contributions to the 457b plan

Age 50+ Catch-up: Individuals aged 50 or older by the end of the calendar year can contribute an additional \$7,500, bringing their total contribution limit to \$31,000.

Age 60-63 Catch-up: A new catch-up provision allows individuals who are 60, 61, 62, or 63 by the end of the calendar year to contribute \$11,250. This increases their total contribution limit to \$34,750.

Make your retirement savings elections in Workday.

Investing

You decide how to invest the assets in your account. The GLWA retirement plans offer a selection of investment options for you to choose from. You may change your investment choices any time by logging into your MissionSquare Retirement account at missionsq.org.



Public Affairs Management Professional Mallorie Stiger's son Aiden and niece Brielle

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 complements 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 \$7,000 for 2024. Age 50 and older may make an additional \$1,000 contribution. Enroll by visiting missionsq.org or by calling 800-669-7400.

Vesting (ownership)

A team member who is 100% vested in his or her account balance owns 100% of the balance.

Team members

- Employer contributions (401a/RHS) — Three years of service
- Team Member contributions (457b, Roth IRA) — Immediately

Apprentices

- Employer Contributions (401a/RHS) — Three years of service beginning the date that you graduate from the program
- Apprentice contributions (457b, Roth IRA) — Immediately

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.

Additional voluntary benefits

UNUM CRITICAL ILLNESS insurance can pay money directly to you when you're diagnosed with certain serious illnesses. If you did not apply when you first became eligible, completion of a statement of health form will be required before your coverage becomes active. Coverage is portable, so you can take the coverage with you if you leave GLWA, and you'll be billed at home.

UNUM ACCIDENT INSURANCE now costs less with an increase in benefit coverage. Accident insurance is designed to pay a lump-sum directly to you for an accidental injury.

UNUM HOSPITAL INSURANCE is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization, and in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital. Team members can use the benefit to meet the out-of-pocket expenses and extra bills that can occur. Lump-sum benefits are paid directly to the team member based on the amount of coverage listed in the schedule of benefits.

For more information or to enroll, submit your election in Workday while completing the Open Enrollment process.

CHUBB LIFE INSURANCE WITH LONG-TERM CARE. For more information or to enroll, visit getltci.com/glwa.

PET INSURANCE BY NATIONWIDE features 70% back on vet bills, one set price, regardless of the pet's age. 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 petinsurance.com/glwater or call 800-872-7387.

Purchasing Power

Purchasing Power is a purchase program sponsored by GLWA that offers a better way to buy the brand-new products you want. Sign up and unlock at least \$250 in Spending Power, even if it's your first day. Then increase your Spending Power just by staying at your employer. You'll quickly power up to \$1,000+ in just 12 months.

With Purchasing Power, you can:

- Shop the brands you love.
- Get your order up front.
- Pay over time, right from your paycheck.

You have fixed, easy payments without the stress that comes with high-interest credit cards. And unlike layaway, you get your order up front. Since 2001, Purchasing Power has helped more than 850,000 people like you buy the big (and sometimes small) things that make life better.

You can sign up for free today and enjoy 20% off your first order! Use Promo code 4Welcome25 valid online only for new customers for 20% off their first order through 12/31/2025 at 11:59pm PT.

Excludes Select New Product Releases, PS5 consoles, Nintendo Switch 2 consoles, Brand & Product Specials, Automotive, Travel, Doorbusters, Flash Sales and Allstate Protection Plans.



Water Technician Basil Jackson and his children enjoying Jamaica

Ulliance – Life Advisor Well-Being Resources

We all know that life can be challenging at times. Issues like illness, debt and family problems can leave us feeling worried or anxious and not able to be at our best. The Life Advisor EAP, sponsored by Ulliance, provides confidential support and resources for you and your dependents at no charge. You can seek expert guidance for any kind of issue, from everyday matters to more serious problems affecting your well-being.

The Ulliance Resolution EAP Model

This program provides short-term counseling with a flexible number of visits. This means you are not limited by a fixed number of counseling sessions or conversations! Ulliance has a solution-based approach focused on resolving or managing your situation

The Ulliance Life Advisor EAP offers:

- **COUNSELING:** Speak to state-licensed and/or certified professionals specializing in short term treatment. You can connect in-person, telephonically, or via video.
- **COACHING:** Get assistance with goal setting and other life achievements via telephonic coaching.
- **CRISIS SUPPORT:** 24/7/365 access to a counselor to assist with an urgent issue or crisis.

Referrals

- **ELDER CARE AND CHILDCARE:** Ulliance provides help finding elder care and childcare services.
- **WORK-LIFE TRANSITIONS:** Get help balancing your work/life commitments. For instance, assistance with aging loved ones, childcare, relationships, parenting, special needs, moving, getting married or having a baby.
- **FINANCIAL:** Free 30-minute telephonic or in-person consultation with a financial counselor to talk about topics such as debt management, financial education, budgeting, or financial planning.
- **LEGAL:** Free 30-minute consultation with a local attorney with a 25% discount on their normal hourly rate. Services include simple dispute resolution, simple will preparation, and other items.



Professional Administrative Analyst Diane Luke enjoying her birthday in South Beach Miami

Ulliance

For more information and resources:
 Download the mobile app
 Call: 800-448-8326
 Go online: lifeadvisor.com



Professional Administrative Analyst Diane Luke with her granddaughters De'ior and Kenned

Liberty Mutual Home and Auto Insurance

Team members gain access to discounted and customized home and auto insurance with a 12-month rate guarantee with the convenience of payroll deduction. To get your free quote:

- Online, log in to the GLWA Savings Center, enter “insurance” in the search box, and the Liberty Mutual option will populate.
- By telephone, call 888-614-3737.



Transformation Management Professional Angela Fears and her husband Antony at Niagara Falls



Treasury Operations Manager Gerri Williams and her husband and sons in Antelope Canyon in Page, AZ

Glossary

APPEAL — A request that your health insurer or plan, reviews a decision that denies a benefit or payment (either in whole or in part).

BENEFICIARY — Person designated as a recipient of funds under a will, trust, insurance policy, etc.

CLAIM — A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services believed to be covered.

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.

DIAGNOSTIC TEST — Tests to determine health problems. For example, an X-ray can be a diagnostic test to see if you have a broken bone.

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 — Providers (doctors/hospitals) that are contracted with the insurance carrier to provide health care services at discounted rates. The in-network costs will be much lower than out-of-network fees.
- Out-of-network — Providers (doctors/hospitals) that are not contracted with the insurance company. If you choose an out-of-network doctor, services you will not be provided 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 healthcare 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.
 - 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 healthcare reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

Required Notices

MEDICARE PART D CREDITABLE COVERAGE NOTICE

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 313-964-5555. **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:	October 1, 2025
Name of Entity/Sender:	Organizational Development
Contact—Position/Office:	Organizational Development
Address:	735 Randolph Detroit, Michigan 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.

**HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY
AND PROCEDURES**

**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.

This notice is provided to you on behalf of:

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Great Lakes Water Authority is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.

- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes: A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common

practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline, provided that you are given a written statement of the reasons for the delay and the date by which the group health plan will complete its action on the request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more

than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

21. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the 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 Plan's Deputy Privacy Official(s) is/are:
Organizational Development

313-964-5555

Effective Date

The effective date of this notice is: October 1, 2025.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

GREAT LAKES WATER AUTHORITY EMPLOYEE HEALTH CARE PLAN

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.***

Contacts

COVERAGE	CONTACT	COVERAGE	CONTACT
MEDICAL	Blue Cross Blue Shield of Michigan 877-790-2583 bcbsm.com Group #: 007041382-0000	TEAM MEMBER PURCHASE PROGRAM	Purchasing Power 888-923-6236 glwa.purchasingpower.com
	Health Alliance Plan 800-422-4641 hap.org Group #: 10004886-1000	TEAM MEMBER WELL-BEING RESOURCES	Ulliance Life Advisor Well-Being Resources 800-448-8326 lifeadvisor.com Download the app
PHARMACY	CVS Caremark 800-678-0382 caremark.com Group #: 1175 (Caremark only applies to BCBSM medical coverage)	CRITICAL ILLNESS, ACCIDENT INSURANCE	Unum 800-635-5597 unum.com Critical illness policy #: 649386 Accident policy #: 987411 Hospital policy #: 987412
DENTAL	Delta Dental of Michigan 800-524-0149 deltadentalmi.com Group #: 10449-0000	VOLUNTARY LIFE INSURANCE WITH LONG-TERM CARE	Chubb 888-407-8175 getitci.com/glwa
VISION	Heritage Vision 800-252-2053 heritagevisionplans.com Group #: 4116-01 (core) and 4116-02 (buy up)	PET INSURANCE	Nationwide 800-540-2016 petinsurance.com/glwater
FLEXIBLE SPENDING ACCOUNTS	Navia Benefits 800-669-3539 naviabenefits.com Employer code: GLW	LIBERTY MUTUAL HOME AND AUTO	For your free quote: 888-614-3737 Customer service: 888-614-3737 GLWA client #: 136810
LIFE/AD&D STD/LTD FMLA/ADAAA REQUESTS	Symetra Leave: 877-377-6773 Life/AD&D: 800-497-3699 STD/LTD: 800-497-3699 symetra.com/mygo Policy #: 16-014923-000	RETIREMENT SAVINGS	MissionSquare Retirement 800-669-7400 missionsq.org
		GLWA ORGANIZATIONAL DEVELOPMENT	735 Randolph Detroit, MI 48226 313-964-9555 onewaterwellness@glwater.org

