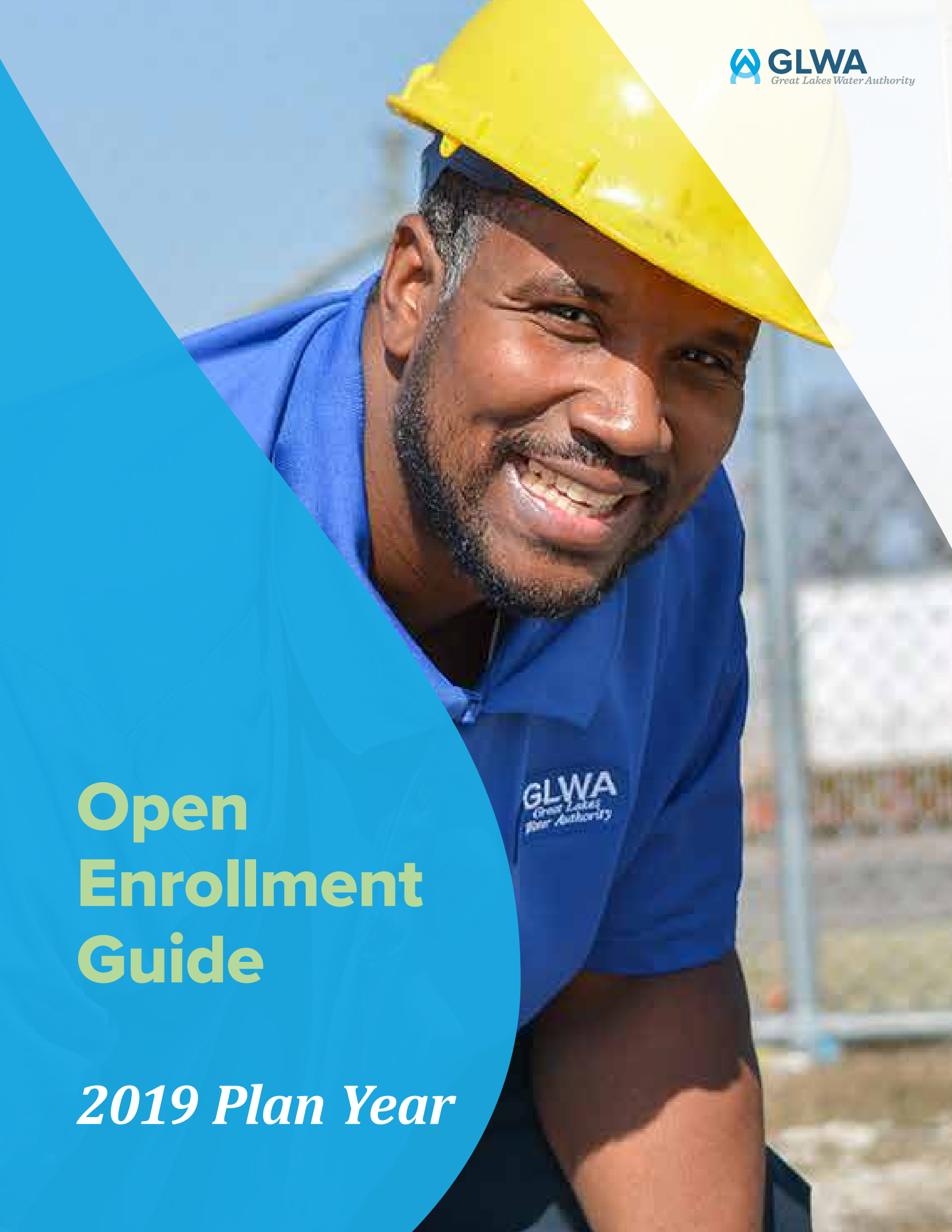
GLWA
Great Lakes Water Authority



Open Enrollment Guide

2019 Plan Year

OFFICE OF ORGANIZATIONAL DEVELOPMENT
735 RANDOLPH ST., 20TH FLOOR
DETROIT, MI 48226
313-964-9800 – GENERAL
313-842-6491 – FAX
www.glwater.org

November 1, 2018

Team Members:

Welcome to Benefits Open Enrollment for the 2019 Plan Year, which runs from November 5 to 16, 2018. GLWA's overall goal is to provide accessible, valuable and affordable healthcare, while exploring innovative solutions to improve the health of our team members and their families. Open Enrollment offers you the opportunity to consider health care coverage, optional life insurance and flexible spending account options for the coming year. The benefits that GLWA provides its team members are an important part of your total compensation and overall wellbeing. We hope that you will take the time to review the available plans and make an informed decision on benefit options for 2018.

GLWA's 2019 Open Enrollment Guide has been mailed to your home, and is available online on the Organizational Development page of our intranet, One Water Connect because:

- We want to be certain you have all the information you need to review GLWA's offered benefit coverage so that you can make the best selection for you and your family, and;

- It gives you an opportunity to review the options privately. The selection of a benefit plan is often a decision made with a spouse or other family members. By receiving the information at home, this helps family members who participate in the decision-making process to have better access to this information.

For the 2019 Plan Year, please be aware that the cost to maintain the coverage provided under the HAP plan has increased due to a market trend of cost increases from 2018 to 2019. We are, however, glad to share that the cost to maintain the coverage provided under the Blue Cross Blue Shield of Michigan (BCBSM) PPO plan has not increased. Also, the cost to maintain the BCBSM dental plan has decreased slightly. As explained in the information sent to you, GLWA contributes 80 percent of the total cost of your health care coverage, while you contribute 20 percent of the total cost. A cost and contribution breakdown is included in the information sent to you.

New for 2019, we have added Telemedicine to the BCBSM plan to match the HAP plan and provide 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. Your regular co-pay for an office visit applies to Telemedicine services.

We also have added a second Heritage Vision Plan as a buy-up option, using their national network to increase provider access. This option includes co-pays, but offers annual exam and lenses, higher

allowances for frames and contacts, coverage for progressive lenses and medically necessary contacts, a fixed fee for contact fitting and out-of-network reimbursement.

Finally, we look forward to introducing you to the BenefitLink App. With your Smartphone, you will have access to essential benefits information at the tip of your finger! The App helps keep your benefit plan information simple and accessible for you and your eligible dependents, and delivers real-time information about your benefit plan.

GLWA is proud to offer our team members a full range of health and wellness benefits. As we move forward together, we will continue to find and review new options and programs that will promote overall health and wellness for each of us, now and into the future.

Yours in Good Health,

Terri Tabor Conerway

Chief Organizational Development Officer

2019 Health Care Per Pay Contributions

BCBSM PPO*	Team Member Pays	GLWA 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 HMO	Team Member Pays	GLWA Pays
Member Only	$55.26	$221.02
Member + 1	$116.04	$464.15
Member + 2 or more	$154.71	$618.86

BCBSM DENTAL	Team Member Pays	GLWA Pays
Member Only	$2.52	$10.08
Member + 1	$5.04	$20.16
Member + 2 or more	$8.82	$35.28

	BASIC PLAN			BUY-UP PLAN	
HERITAGE VISION	Team Member Pays	GLWA Pays		Team Member Pays	GLWA 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

You're a valued member of the Great Lakes Water Authority, 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 2019 plan year and consult your Organizational Development (OD) team member with any questions.

TABLE OF CONTENTS

See **page 23** for important information concerning Medicare Part D coverage.

Shavarn Smith, Professional Administrative Analyst, Financial Services, Water Resource Recovery Facility. My husband and I on a trip to Europe.

Cover credit: Lorrance Lewis, Maintenance Technician, Field Services
"What I like about working for GLWA is knowing I have the opportunity to help improve the quality of life in southeast Michigan by helping to deliver clean, fresh water to millions of people."

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 Great Lakes Water Authority 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

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, 2019. Due to IRS regulations, once you have made your choices for the 2019 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.

Blair Copeland, Office Support Specialist, Organizational Development, Water Board Building
Blair's daughter Mila enjoying her annual Wellness Check-up

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.

Rasiklal Patel, Chemist, Wastewater Operations, Water Resource Recovery Facility
Spending time with my grandson, Anay

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.

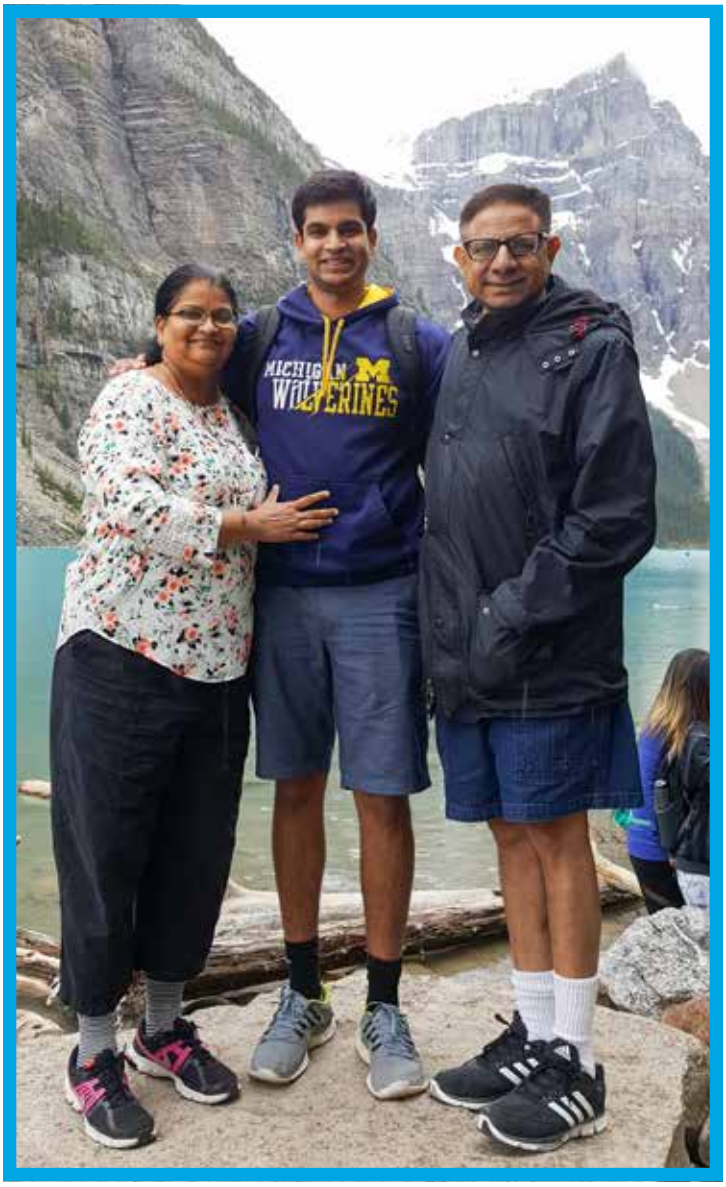
See HOW TO FIND A PROVIDER (page 7) to verify your doctor participates in the plan your are considering.

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.



WWP Pink Out the Plant
Esther Williams, Andrae Savage and Yvette Hayes-Johnson, Water Works Park Water Treatment Plant

Ravi Yelamanchi, Engineer, Wastewater Operations, Water Resource Recovery Facility
Family vacation to Calgary, Canada with my son, Aditya, and wife, Ratna.

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 and please keep in mind that the option you elect will be in place for all of the 2019 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 2019 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

New for 2019, we have added telemedicine to the BCBSM plan to match the HAP plan and provide 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. Your regular co-pay for an office visit applies to Telemedicine services.

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

Jackie Morgan, Management Professional, Financial Services, Water Board Building
Jackie participating in the 2018 Detroit Free Press Marathon

	BCBSM COMMUNITY BLUE PPO PLAN	HAP HMO PLAN
BI-WEEKLY CONTRIBUTIONS		
TEAM MEMBER ONLY	$55.81	$55.26
TEAM MEMBER + 1	$117.20	$116.04
TEAM MEMBER + 2 OR MORE	$156.26	$154.71

	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
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!

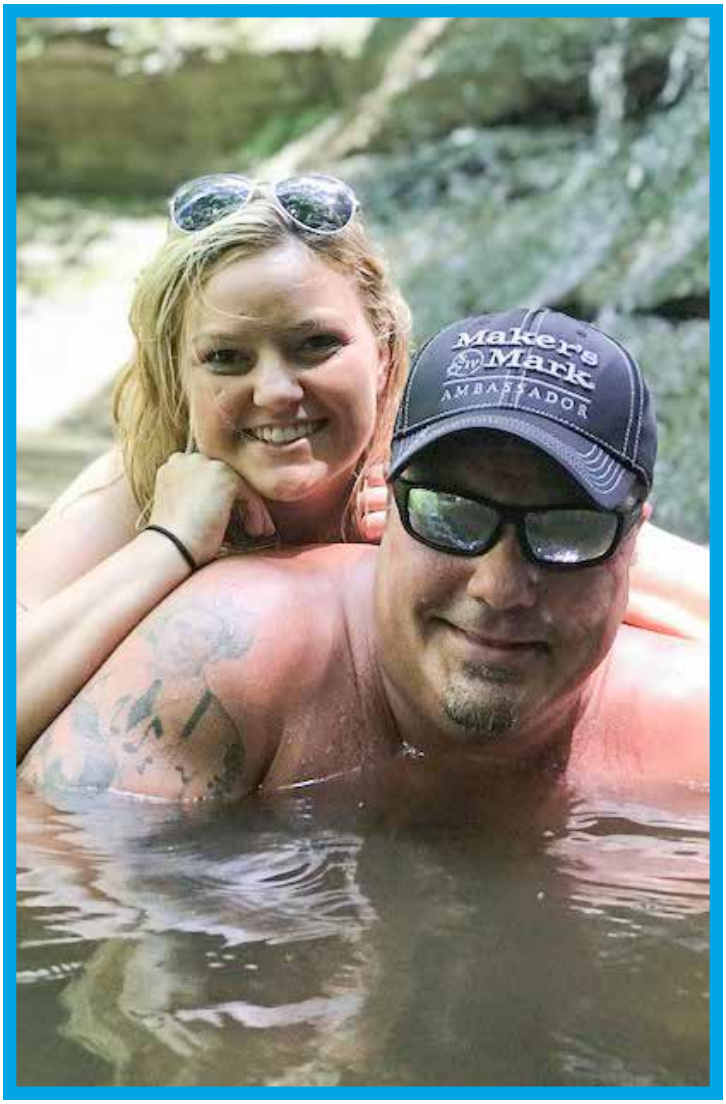
Any screening test done in order to catch a disease early is considered a preventive service. Due to the U.S. Patient Protection and Affordable Care Act (ACA), many services, screenings and supplies are paid at 100% including, but not limited to, the following:

- 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.



Nickie Bateson, Chief Financial Officer, Financial Services, Water Board Building
Nickie and her husband Doug running a half marathon in Wilmington, DE.

Mark Ragsdale, Maintenance Manager, Wastewater Operations, Water Resource Recovery Facility
Swimming in a pool of water at the bottom of a water fall at Still Hallow Falls, Tennessee with his daughter, Tori.

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 SUPPLY)		
GENERIC	$10	$10
PREFERRED	$35	$35
NON-PREFERRED	$50	$50
MAIL ORDER RX (90 SUPPLY)		
GENERIC	$20	$20
PREFERRED	$70	$70
NON-PREFERRED	$100	$100

Curtis Burris-White, Public Affairs Specialist, Public Affairs, Water Board Building
Participating in the 2017 Making Strides Against Breast Cancer Walk with my daughter, Savannah

Stephanie Stevenson, Organizational Development Director, Organizational Development, Water Board Building
Family enjoying the sunset at Menemsha Beach on Martha's Vineyard.

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.

Alfreado Lava, Engineer, Wastewater Operations, Water Resource Recovery Facility
Enjoying a family vacation at Michigan's Adventure Wave Pool!

Gary Stoll, Jr., Engineer, Wastewater Operating Services
"One reason I like coming to work at GLWA is my group's mission to best serve the Combined Sewer Overflow operations. I enjoy being part of the regional system to protect the environment."

DENTAL BENEFITS

Regular dental checkups do more for your well-being than just preserve a healthy smile. GLWA's dental coverage will provide you and your family affordable options for overall health. Coverage is available from Blue Cross Blue Shield of Michigan.

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 Blue Cross Blue Shield of Michigan at www.bcbsm.com or call 877-704-2583.

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 2019 dental coverage provided by Blue Cross Blue Shield of Michigan. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

DENTAL PLAN

	BI-WEEKLY CONTRIBUTIONS	
TEAM MEMBER ONLY	$2.52	
TEAM MEMBER + 1	$5.04	
TEAM MEMBER + 2 OR MORE	$8.82	
	IN-NETWORK	**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
	COVERED SERVICES	
PREVENTIVE SERVICES	100%	50%
BASIC SERVICES	80%	50%
MAJOR SERVICES	50%	50%
ORTHODONTICS	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.

Lynn Herrick, IT Manager, Strategic Planning
"One of the things that makes me proud to work for GLWA is the level of professionalism and capability of my colleagues. It's really satisfying to work with people who care about what they're doing and are good at what they do."

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 2019 vision coverage provided by Heritage Vision.

	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				
NECESSARY			100% covered	Reimbursed up to $200
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

Eye doctors are often the first health care professionals to detect chronic systemic diseases such as high blood pressure and diabetes.

Robin George, Chemist, Northeast Water Plant
"I am proud to be on a team of such knowledgeable, dedicated people who are working around the clock to provide our customers with clean, great tasting water. It also feels great to know the work we do helps to keep our communities happy and healthy!"

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 $2,650 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 $500 may be rolled over to the next plan year at the end of 2019 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.

Zechariah Gross, Professional Administrative Analyst, Organizational Development
"GLWA allows me an opportunity to be creative and be a part of an environment that supports collaboration. The influence I am able to have on my fellow team members has made my working experience here at GLWA very rewarding."

Commuter Benefits

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

Parking Reimbursement Account

You may set aside up to $255 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.

Elizabeth Dulinski, Professional Administrative Analyst, Financial Services, Water Board Building
Enjoying a day at the cider mill with my whole 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 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 age 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.

Your beneficiary doesn't have to be a person. A trust, or a legal agreement that lets you place property under the control of a trust manager, can be named the beneficiary. The beneficiary can also be a charity or simply your estate. For assistance with this option, contact Organizational Development, 313-964-9555.

Joseph Luttrell, Chemist, Water Operations, Lake Huron Water Plant.

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, 2019)	TEAM MEMBER	AGE (AS OF JANUARY 1, 2019)	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 refer to your plan documents for details or contact OD for specific benefits.

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.

GLWA Financial Services Halloween

Eric Kramp, Manager, Water Operations and Field Services and Engineering, Water Works Park
Tired from a day of fun at Pennsic with my daughter Lucy

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 effective January 1, 2019, a Roth IRA plan.

Christopher Steary, Manager, Water Operations, Lake Huron Plant
Chris and his family zip lining.

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 deferral 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 $18,500 for 2019.

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 2019 — for a combined total contribution allowance of $24,500. 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 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 roll over 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 (401a)

GLWA deposits a contribution equal to 6% of your annual base pay into a 401a account in your name. Also, GLWA will match your 457b contribution, up to 3%, and 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: New for 2019

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 $5,500 for 2019. Age 50 and older may make an additional $1,500 contribution. Enroll by visiting www.icmarc.org or by calling 800-669-7400.

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.

Adino May, Professional Administrative Analyst, Organizational Development, Water Board Building
Adino's grandson, Josiah

Cora Riley, Maintenance Technician, Southwest Water Plant

GLOSSARY

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) 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% 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.

Adino May, Professional Administrative Analyst, Organizational Development, Water Board Building
Adino with her daughter and the dolphins while vacationing in Jamaica

- 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.

GLWA Volunteers at The Children's Center Holiday Shop

Required Notices

Important Notice from The Great Lakes Water Authority About Your Prescription Drug Coverage and Medicare under the Blue Cross Blue Shield of Michigan and HAP Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Great Lakes Water Authority and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Great Lakes Water Authority has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Michigan and HAP plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare 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. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The Great Lakes Water Authority coverage 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 herein.

If you do decide to join a Medicare drug plan and drop your current The Great Lakes Water Authority coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Great Lakes Water Authority and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Important Notice from The Great Lakes Water Authority About Your Prescription Drug Coverage and Medicare under the Blue Cross Blue Shield of Michigan and HAP Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Great Lakes Water Authority and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Great Lakes Water Authority has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Michigan and HAP plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the The Great Lakes Water Authority plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from The Great Lakes Water Authority. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare 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. You may also enroll each year from October 15th through December 7th.

However, if you decide to drop your current coverage with The Great Lakes Water Authority since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the The Great Lakes Water Authority plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The Great Lakes Water Authority coverage 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 herein.

If you do decide to join a Medicare drug plan and drop your current The Great Lakes Water Authority coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under The Great Lakes Water Authority is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed at the end of these notices for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Great Lakes Water Authority changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2019
Name of Entity/Sender:	The Great Lakes Water Authority
Contact—Position/Office:	Organizational Development
Address:	735 Randolph Detroit, MI 48226
Phone Number:	313-964-9555

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact OD at 313-964-9555.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. The Notice of Privacy Practices has been recently updated. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact OD at 313-964-9555.

HIPAA 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 towards 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 (i.e. legal separation, 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 coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 60 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 the 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 towards 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 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact OD at 313-964-9555.

Notice of Grandfathered Status

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 313-964-9555. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

NOTES

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	Blue Cross Blue Shield of Michigan 877-709-2583 www.bcbsm.com Group #: 007041382-0001
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
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

Kashmira Patel, Engineer, Wastewater Operating Services
"I am proud to work with GLWA because of its diversity and professionalism. I love working as One Water One Team to service our communities effectively and efficiently with the best CSO team!"

GLWA
Great Lakes Water Authority

ONE WATER WELLNESS

HEALTHY LIVING

FINANCIAL

PREVENTIVE CARE

MOVEMENT