GLWA
Great Lakes Water Authority

OPEN ENROLLMENT GUIDE

PLAN YEAR 2018

ENROLLMENT PERIOD

November 6 - November 17, 2017

Table of Contents

OPEN ENROLLMENT

Introduction

GLWA's comprehensive benefits package is designed to ensure the well-being of you and your family. Whether it's health care, income protection, retirement savings or other benefits such as the Employee Assistance Plan, we've got you covered.

While reviewing GLWA's health care plans, please consider all of your options. While GLWA's benefits are comprehensive, your spouse may be offered coverage options better suited to the needs of your family.

Profile Updates and Dependent Data Updates

Before beginning the Open Enrollment process, please take the time to carry out a little "profile housekeeping" in Dayforce. Has your home address changed? Is your profile missing your work phone, home phone or cellphone? Are the social security numbers for all of your dependents listed on their records?

To make changes to your profile, after you have logged in, click on the "Profile and Settings" icon on your Dayforce home page, or by using the left-hand short-cut menu.

The items that you can update on your Profiles and Settings page are:

- Home and cell phone numbers;
- Adding your personal email address;
- Emergency contacts.

In order to update dependent information, please click on the "Forms" icon on your home page. Then click on "Current Dependent Information," and update your dependent's information.

Enrolling in Coverage

For this enrollment period, we have an active portion and a passive portion.

Active Enrollment process*: If you wish to participate in the Health Care and/or Dependent Day Care Flexible Spending Accounts (FSAs) in 2018, you must enroll or re-enroll in those plans. They will be offered as an option on your online benefits enrollment worksheet. In addition, now is the time to increase, decrease, enroll or cancel your optional life coverage.*

Passive Enrollment Process: ***Medical, dental and vision plans are part of the passive process. This means that if you wish to continue with the same medical, dental and vision plans in which you are currently enrolled today, you do not have to take any action for 2018. Those plans and elections will simply carry forward from 2017 into 2018.***

When Will My Coverage Become Effective?

All plans and/or election changes will become effective on January 1, 2018.

When Can I Enroll?

Open Enrollment is Monday, November 6 - Friday, November 17, 2017.

If you wish to make changes to your current enrollment, or enroll in a new plan, you must do so within this Open Enrollment period. You MUST take action if:

- You wish to make any changes to your medical, dental or vision coverage;
- You wish to enroll in the health care or dependent day care flexible spending accounts;
- You wish to enroll in the optional life plans.

Who Can I Cover?

You have the option of enrolling yourself and your eligible dependents in medical, dental and/or vision benefits. Eligible dependents include:

Eligible Dependents	Coverage
Your Spouse	All coverage
Children up to the age of 26	Medical coverage
Children up to the age of 19	Dental and Vision coverage
Children ages 19 – 25, who are enrolled as full-time students at an accredited college, university or trade school	Dental and Vision coverage
Unmarried children at any age who are incapable of supporting themselves due to a mental or physical disability, and are truly dependent on you.	All coverage

If you are enrolling a new dependent or re-enrolling a dependent previously determined to be ineligible, you will be required to upload supporting documentation confirming your dependent's relationship to you. Supporting documents include:

Eligible Dependents	Required Documents
Your Spouse	Copy of marriage certificate AND confirmation of joint ownership of a home or joint bank account
Children up to the age of 26 for medical coverage	Copy of the child's birth certificate
Children up to the age of 19 for dental and vision coverage	Copy of child's birth certificate
Children ages 19-26 for dental and vision coverage (if full-time students at an accredited university, college or trade school)	Copy of registration or a print screen of class registration for the current semester
Unmarried children of any age who are incapable of supporting themselves due to a mental or physical disability, and who are totally dependent on you	Copy of the Social Security Administration determination of permanent disability

Please Note: If a dependent has been enrolled due to a Qualified Medical Child Support Order, additional documentation is not required.

What If Things Change?

The benefits you choose will be in place for the entire 2018 calendar year. IRS rules do not allow you to make changes during the year unless you experience a qualified life event. You will have 60 days from the date of that event in order to make eligible changes to your benefit plan elections and the dependents you cover.

Qualified life events include, but are not limited to:

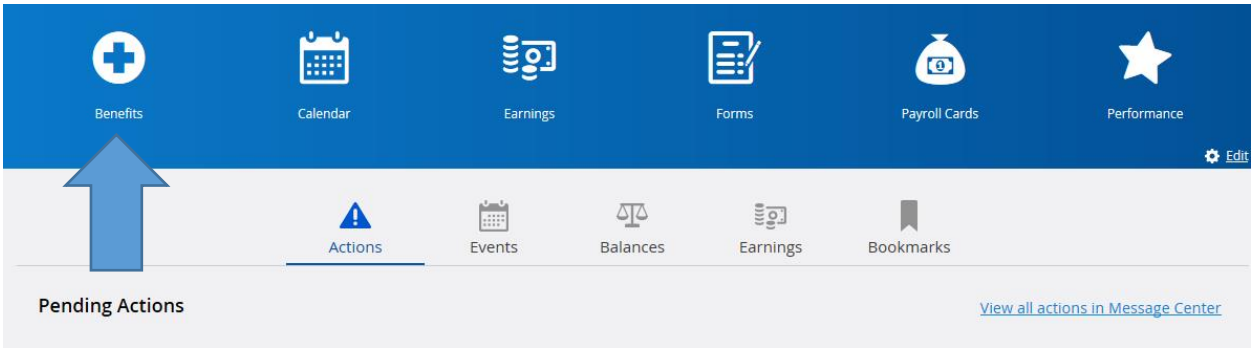
- Marriage;
- Legal separation or divorce;
- Death of your spouse or birth/death of a dependent child;
- The loss or gain of employment and/or benefit coverage by your spouse;
- Your spouse or dependent's losing or gaining coverage.

If you make a coverage change due to a life event, the effective date of that change will be the date of the event. This may result in a retroactive increase or decrease in the cost of that coverage. Please be prepared for the potential for arrears (contributions due) or a refund.

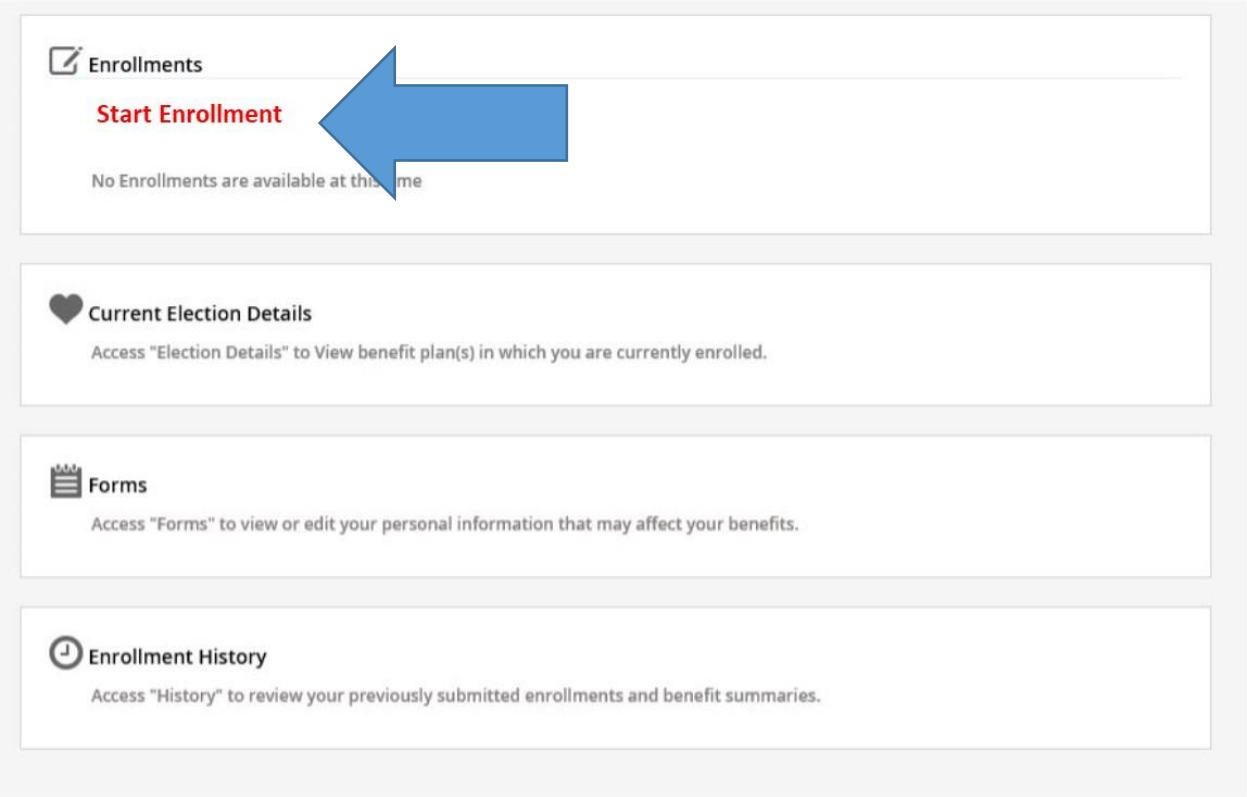
Enrollment

How Do I Enroll?

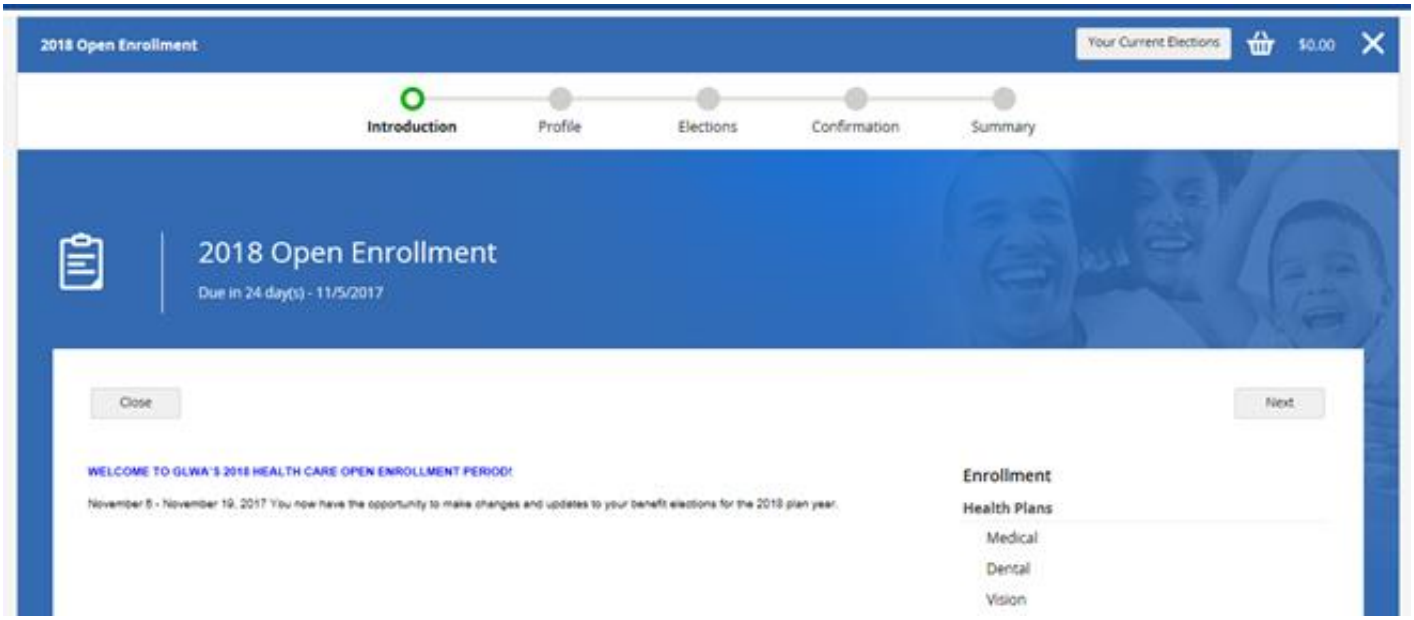
Step 1. Once you have logged into Dayforce, click on the Benefits icon on your homepage. You will be taken to your benefits enrollment screen.



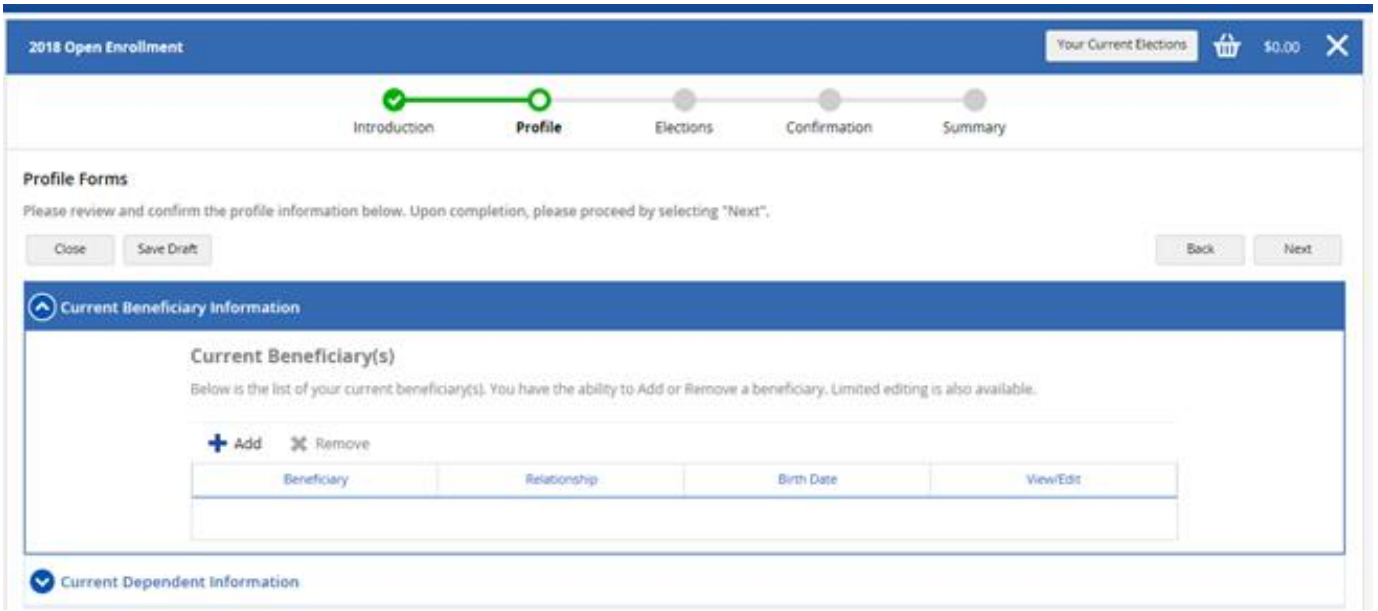
Step 2. Click on "Start Enrollment."



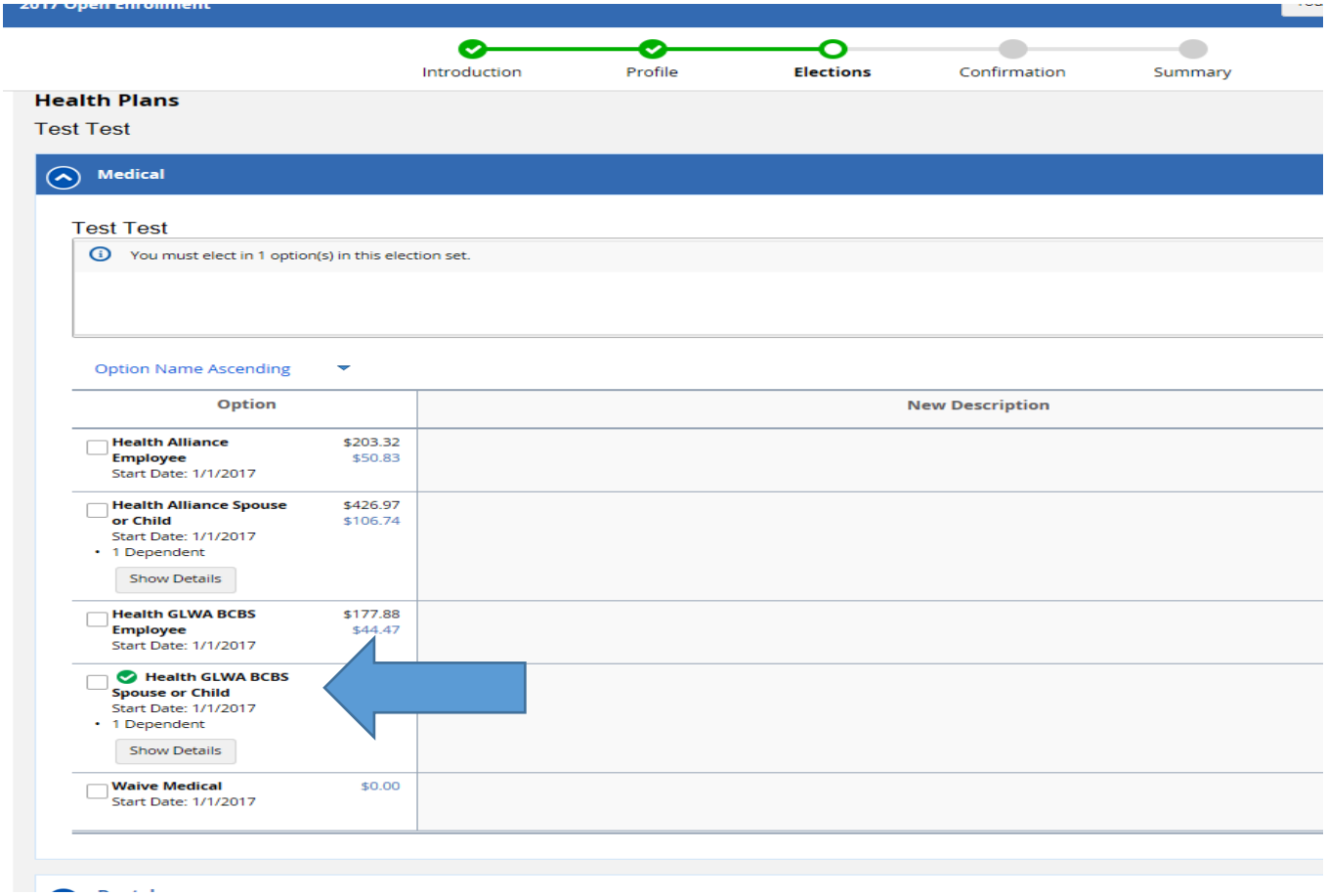
Step 3. You will be taken to the Open Enrollment site, where the enrollment process will begin.



Step 4. First, update and enter any missing personal data for dependents who you intend to enroll in coverage. Be certain to have your dependent(s) social security numbers handy, as well as the beneficiaries for your life insurance benefits.



Step 5. You will be guided, plan-by-plan, through the enrollment process. The option in which you are currently enrolled will be displayed with a green "√." If you wish to remain enrolled in that plan for 2018, simply click on the box next to the green "√." If you wish to enroll in another benefit option, click the box next to that option.



Step 6. Review each plan and make your enrollment elections for each of the plans listed.

What if I Don't Enroll Now?

If you do not enroll during *this* Open Enrollment, you will have to wait until the *next* Open Enrollment period to enroll in coverage for the 2019 plan year, unless you experience a qualified life event (***see page 5 for qualified life events***).

HEALTH CARE BENEFIT OPTIONS

GLWA offers team members two comprehensive, high-quality medical plan options, both with prescription drug coverage.

Blue Cross Blue Shield of Michigan Medical PPO

The Blue Cross Blue Shield of Michigan (BCBSM) PPO (Preferred Provider Organization) offers the convenience of allowing you to see any health care provider that you wish. However, if you use a health care provider that is in the Blue Cross Blue Shield network, your out-of-pocket expenses will be less.

BCBSM has a nationwide network of providers including, but not limited to doctors, hospitals and laboratory/x-ray facilities. If you have a dependent who is enrolled in school in another state, BCBSM is the plan that would work best for you.

CVS Caremark Pharmacy Benefit

As a BCBSM plan participant, your prescription drug coverage is administered by CVS Caremark (Caremark). You will receive a separate prescription drug ID card from Caremark. Although Caremark administers the prescription drug program for BCBSM enrollees, you may use any pharmacy that accepts the CVS Caremark card. You are not limited to CVS and Target/CVS pharmacies. CVS Caremark cards are accepted at all major pharmacies, such as Walgreens and Kroger, as well as smaller pharmacies like Midtown RX Pharmacy or Southwest Discount Pharmacy.

There are special rules for participants who are using a maintenance medication. A maintenance medication is a drug that someone takes for more than six-months, and is used to treat a chronic medical condition. For example, prescription medications that are used to treat high blood pressure (hypertension) and diabetes are considered maintenance medications.

Maintenance medications must be purchased either through the Caremark mail order program, or from a CVS or CVS/Target pharmacy. Your physician must write your prescription to provide 90-days of medication per fill, with three (3) refills of medication. Contact Caremark with any questions.

BCBSM plan participant drug coverage

Use any pharmacy that accepts the CVS Caremark card (all major pharmacies)

All maintenance medications must be filled through Caremark mail order OR filled at a CVS/CVS Target pharmacy AND must be filled for 90-day prescriptions

Health Alliance Plan HMO

Health Alliance Plan (HAP) is an HMO (Health Maintenance Organization). Under an HMO, you and your family members will each choose a "primary care physician" (PCP). Your PCP provides or directs all of your health care. If you require specialized medical care, your PCP will handle the referral. ***Please note: if you seek care, other than emergency services, without your PCP's written authorization, your care may not be covered.***

Prescription Drug Coverage: As a HAP plan member, your prescription drug coverage is administered by HAP, your HAP ID card can be used for both the HAP medical and prescription drug coverage.

Medical Benefit Plan Comparison Chart

Key Features	**BCBSM Community Blue PPO Plan**		**HAP HMO Plan**
	In-Network	Out-of-Network	In-Network
Annual Calendar Year Deductible			
Individual	$750	$1,500	$750
Family	$1,500	$3,000	$1,500
Coinsurance Out-of-Pocket Maximum			
Individual	$1,500	$4,500	$1,500
Family	$3,000	$9,000	$4,500
Out-of-Pocket Maximum (includes all deductibles, coinsurance, office visits and prescription drug copays)			
Individual (includes deductible)	$6,350	$12,700	$6,350
Family (includes deductible)	$12,700	$25,400	$12,700
Coinsurance (portion you pay)	20% for most services	40% for most services	20% for most services
Office Visit – Primary & Specialist	$25	40% after deductible	$25
Preventive Care	100% coverage	Not covered	100% coverage
Lab and X-ray Services	20% after deductible	40% after deductible	20% after deductible
Hospital Services			
Inpatient Hospital (per admission)	$100 copay, then 20% after deductible	40% after deductible	$100 copay, then 20% after deductible
Urgent Care Copay	$25	40% after deductible	$25
Emergency room copay (waived if admitted)	$100	$100	$100
Retail Prescriptions (30-day supply)	**CVS Caremark**		**HAP**
Generic	$10		$10
Preferred brand	$35		$35
Non-preferred brand	$50		$50
Mail-Order Prescriptions (90-day supply)	*Mandatory Mail Order with CVS Caremark*		
Generic	$20	*N/A*	$20
Preferred brand	$70		$70
Non-preferred brand	$100		$100

Blue Cross Blue Shield Dental

Dental care is important to your overall health and wellness. GLWA's dental plan with BCBSM offers a network of participating dentists and specialists who have agreed to provide services at a discounted cost. If you use these providers, your out-of-pocket costs will be less. You are free to use providers that do not accept BCBSM's reimbursement pricing; however, that dentist may charge you for the difference between the amount they billed and what BCBSM Dental approved.

The chart below summarizes BCBSM Dental Plan benefits.

Key Features	**Blue Cross Blue Shield of Michigan** Dental Plan
Annual Calendar Year Maximum Benefit	$1,000
Calendar Year Deductible	
Individual	$0
Family	$0
Preventive Services	100% Coverage
Basic Services	20%
Major Services	50%
Orthodontia (Includes over age 19)	50%
Lifetime maximum	$1,000

Heritage Vision Plan

At work or at home, being able to see clearly is important. Whether you are reading a control instrumentation panel at a plant, or a recipe at home, good vision is critical. Serious medical conditions such as hypertension, diabetes and brain tumors can also be identified early through eye exams.

The Heritage Vision Plan is a "closed network" plan. This means that you must use vision care providers within the network in order to receive full benefits.

An approved list of GLWA in-network vision care providers is available by contacting Heritage Vision directly (we should insert a website or phone number), or from the Organizational Development team.

The chart below summarizes Heritage Vision Plan benefits.

Key Features	**Heritage Vision**	
	In-Network	**Out-of-Network**
Exam	100% coverage, no copay	$30 allowance
Lenses (standard single vision, bifocals and trifocals)	100% coverage, no copay	Single Vision - $30 allowance Bifocal - $40 allowance Trifocal - $50 allowance Progressive - Not covered
Frames	$100 allowance, no copay	
Contact Lenses ***Instead*** of Glasses	$45 allowance	
Conventional/Disposable Medically Necessary	$90 **total** allowance, no copay (Exam, Fitting and Contact Lenses)	$45 allowance
Exam and Material Benefit Frequency is once every 24 months		

Optional Life Insurance

Providing a full range of benefits to protect you and your family is important to GLWA. That is why during Open Enrollment, GLWA offers team members the opportunity to purchase additional life insurance for themselves, their spouses and their dependent children. Following is a summary of the available benefits. ***Purchase of employee optional coverage is required in order to purchase optional spouse and/or optional child coverage.***

Optional Term Life Insurance		
	Employee	**Spouse**
Life Benefit	Choose to purchase benefits in $10,000 increments. Minimum Amount: $10,000 Maximum Amount: $500,000	Choose to purchase benefits in $10,000 increments. Minimum Amount: $10,000 Maximum Amount: $250,000 ***Purchase of employee coverage is required in order to purchase spousal coverage.*** ***Spousal coverage cannot exceed 100% of the employee's coverage.***
Benefit Age Reductions	35% reduction of benefits at age 65 15% additional reduction at age 70	

Child Life Benefit For eligible children ages 14 days to 26 years old, amounts can be purchased in $2,500 increments, up to $10,000. The benefit for children less than 14 days old is $1,000. **Proof of Good Health - Required for all new enrollments, or for increases greater than one level.** ***Purchase of employee member coverage is required to purchase child coverage.***	
	Age reductions apply to the benefit amount after approval of evidence of good health (if necessary)
Proof of Good Health	**Required for all new enrollments, or for increases greater than $10,000.**

Optional Life Insurance Rates

Optional life insurance is charged at a rate per $1,000 of coverage. Please find the rates for the 2018 plan year in the chart below. There is also an example that will help you determine what your per pay cost will be. Plus, as you make your election in Dayforce, the system will automatically present you with the per-pay amount and the annual cost of coverage.

The calculation for determining the cost of coverage is:

Amount of insurance / $1,000 x the rate = monthly cost of coverage

Monthly cost of coverage x 12 months / 26 pay periods = per pay cost of coverage

Example: David is 44 years old, and has a 39-year-old spouse. They have two teenaged children. David is considering purchasing:

- $125,000 in coverage for himself;
- $100,000 in coverage for his spouse; and
- $5,000 for his children.

David – 125,000 / $1,000 x .209 x 12 / 26 = $12.06 per pay
Spouse – 100,000 / $1,000 x .129 x 12 / 26 = $5.95 per pay
Children – 5,000 / $1,000 x 1 x 12 / 26 = $2.31 per pay (this is the total cost for child life regardless of the number of children insured)

Optional Term Life Monthly Rate per Thousand		
Age	**Employee**	**Spouse**
29 & under	$.078	$.078
30-34	$.086	$.086
35-39	$.129	$.129
40-44	$.209	$.209
45-49	$.322	$.322
50-54	$.525	$.525
55-59	$.825	$.825
60-64	$1.144	$1.144
65-69	$2.112	$2.112
70 & over	$3.466	$3.466

Child Life Monthly Rates per Thousand
$2,500 - $.50 per family
$5,000 - $1.00 per family
$7,500 - $1.50 per family
$10,000 - $2.00 per family

Please note: You must choose a beneficiary for optional employee life coverage. You are automatically the beneficiary for spouse and child coverage.

FLEXIBLE SPENDING ACCOUNTS

GLWA offers three types of Flexible Spending Accounts (FSA) each of which allow you to save money on a pre-tax basis to pay for eligible medical, dental, vision, dependent day care and commuter expenses. Navia Benefit Solutions administers these plans on GLWA's behalf.

IMPORTANT NOTE: You must re-enroll in the healthcare and Dependent Day Care FSA each benefit year!

Health Care FSA	Dependent Day Care FSA	Commuter FSA
Enroll via Dayforce: This account allows you to deposit money on a tax-free basis into an account, from which you can pay for eligible medical, prescription drug, dental and vision expenses. Using your Navia debit card, you can pay for out-of-pocket expenses such as prescription drug and office visit copays, dental coinsurance and vision expenses in excess of the amount the plan covers. The maximum amount that you can elect is $2,650 for the 2018 plan year. Your entire election amount is immediately available to you, even if your account is not fully funded. However, plan wisely. ***If you are not able to use your entire election, you will only be able to carry-over a maximum of $500 of unused funds from one plan year to the next.***	**Enroll via Dayforce:** Use this FSA for reimbursement of eligible child day care or elder care expenses. You can elect to contribute up to $5,000 each calendar year. The dependent child(ren) must be under the age of 13. Both, children and elder care recipients must be declared as dependents on your Federal IRS 1040 Form. Day care expenses provided by immediate family members are not reimbursable, and the caregiver's EIN/SSN must be submitted on the claim for payment. If you have questions on eligible expenses, contact Navia for assistance. ***Unlike the health care FSA, your contribution amounts are only available for use as they are deposited throughout the year, and you cannot roll over any unused funds. Any unused funds are forfeited.***	**Enroll via Navia Benefits:** If you use public transportation to get to work, or have to pay for parking at work-site location, GLWA offers Flexible Spending Accounts (FSAs) specifically designed to allow you to pay for those expenses with tax-free dollars. You can enroll for up to $260 per month for parking or transit expenses.

Please Note: To enroll in either the commuter FSA, you will make those elections directly into Navia's system. If you have not yet registered with Navia, you will need to do so first. Go to https://naviabenefits.com, and click on the "register" icon. Once you have registered, you will be asked to log in with the username and password that you established during registration. Once you have logged-in, click on the GoNavia Transit/Vanpool icon for bus or vanpool expenses, or GoNavia Parking icon for parking expenses. Follow the instructions to place your order. Use company code GLW. This

plan does not require an annual election. You can enroll on a monthly basis, and even make your election recurring – from month-to-month. Any orders placed by the 20th day of one month, will become effective the following month. For example, orders placed by March 20, will cover eligible parking or transit expenses for the month of April.

Your pre-tax contribution for the Commuter FSA will be taken from the first pay of the month in which you are participating. Your reimbursement can be automatically loaded to a debit card to pay the parking or transit vendor. However, if you prefer to be reimbursed directly, simply choose the "Pay Me Directly" option when placing your order. You can even enjoy the convenience of direct deposit by providing Navia with your bank account routing and account number.

GREAT PLANS TO REMEMBER

GLWA also provides several benefit plans for which we pay the cost. They are FREE OF CHARGE to you and designed to help protect you and your family financially. You are automatically enrolled as soon as you become eligible.

Life and Accidental Death and Dismemberment Insurance

GLWA provides each team member with life insurance coverage in an amount equal to 1 ½ times your base annual earnings up to $300,000. Accidental death and dismemberment (AD&D) insurance offers additional coverage in the event you have severe injuries resulting in the loss of all or part of a limb, your sight, your hearing, or your death is due to an accident. Your AD&D coverage also equals 1 ½ times your base annual earnings up to $300,000. The minimum benefit will be $50,000, unless you have a reduction in benefit due to age.

Disability

Disability plans replace a portion of your income if you are unable to work because of a serious non-occupation (not work) related illness or injury.

- Short-Term Disability (STD): If you are unable to work for 15 or more consecutive calendar days due to an eligible injury or illness, this benefit pays 50 percent of your weekly pay to a maximum benefit of $2,500 per week. This benefit begins on the 15th day of disability and can continue for up to 24 weeks while you are disabled.

  You are eligible to receive STD benefits if, due to illness or injury, you are unable to perform the majority of the essential functions of your job. For example: Donna is a Maintenance Technician who has broken her leg. It's a simple fracture, but her leg will be in a cast for at least eight weeks. Because she is unable to perform a Maintenance Technician's essential job functions, she will be eligible for STD benefits.

Please Note: Team Members in the Apprenticeship Program are eligible for enrollment in the STD plan after completing one full year in the Apprenticeship Program.

- Long-Term Disability (LTD): This benefit pays a portion of your income if you continue to be disabled, and your STD benefits have been exhausted. To qualify, you must have been disabled for 180 continuous days. LTD coverage will provide 50percent of your base monthly earnings to a maximum of $10,000 per month.

  You are eligible to receive LTD benefits if, due to illness or injury, you are unable to perform the majority of the essential functions of your job for the first year you receive benefits. After you have been disabled for a total of two years, you will be eligible to continue to receive benefits if your disability makes it impossible for you to perform the essential functions of any job for which you are qualified by education, training or experience. For example: David is an Engineer who suffered a stroke six months ago. Although in a rehabilitation program, he has difficulty speaking and has continued paralysis. Instead of working in a water treatment plant, David's education and training would allow him to teach, or work in a non-industrial setting. However, his physical condition is such that he is unable to perform the essential functions of any profession for which he has education, training or experience. Therefore, he will be eligible for LTD benefits.

  LTD benefits will generally be payable until you reach the Social Security Administration defined normal retirement age, as long as the team member remains eligible for benefits.

  LTD has a provision that significantly limits benefits for conditions that existed before team members enrolled in coverage. A pre-existing condition is an illness or injury, for which you:

  - Received medical treatment, had consultation, received care, and/or;
  - Were prescribed or took prescription medications in the three (3) months prior to your effective date under this plan.

If you have a pre-existing condition, disability benefits will not be payable for disabilities resulting from that condition until you have been enrolled for at least 12 consecutive months and you are "actively at work" on your anniversary date.
Note: Team Members in the Apprenticeship Program are eligible for enrollment in the LTD plan after the successful completion of the Apprenticeship Program and placement with GLWA for full-time employment.

Both the life and disability plans are managed by Principal Financial.

EMPLOYEE ASSISTANCE PROGRAM

Through the Employee Assistance Program (EAP) administered by Health Management Systems of America (HMSA), you and eligible members of your household have 24/7 access to confidential counseling to help address issues such as relationship struggles, drug and alcohol abuse, financial planning and aging well. The EAP also provides tips and resources on parenting, health and wellness and even the best kind of pet for your family.

The program includes up to three (3) EAP sessions per situation. Many issues can be resolved directly with an EAP professional; however, in some cases, you may be referred to other resources. Some of these resources may be a qualified expense under your medical plan. Please check with your healthcare plan for assistance, before you seek care from a referral resource.

You can speak with an EAP representative 24 hours a day, seven days a week by calling 800-847-7240, or you may visit HMSA's website at **www.my-life-resource.com**. The company username is **hmsa** and the password is **myresource**.

RETIREMENT PLANS

GLWA believes in helping you plan for a comfortable retirement. Everyone should have a nest egg that is funded enough to cover their daily expenses in retirement. GLWA retirement plans are ***very*** generous and can take the worry out of life after you stop working. The Authority's retirement plans take a three-plan approach to your retirement nest egg. Those plans are: the 401a plan; the 457b plan and the Retirement Healthcare Savings Plan (RHSP). Each plan plays a unique role in making your retirement a successful one. ICMA-RC administers each of these retirement plans.

There is a "vesting" period for the 401a and the RHSP. "Vesting" is the time period beginning when you were first hired as a full-time employee to a specific point in the future at which you become the owner of the money accrued in those accounts. The GLWA vesting period is three (3) years. This means that after you have been employed by GLWA for three continuous years, you own the accumulated value of those plans. There is no vesting for the 457b plan.

Note: Team Members who are hired through the Apprenticeship Program are vested after seven (7) years of service, which includes their years as an apprentice.

401a – In this plan, on each pay date, ***GLWA*** contributes six percent (6%) of your base earnings to your 401a account. This happens automatically and does not require you to take any action.

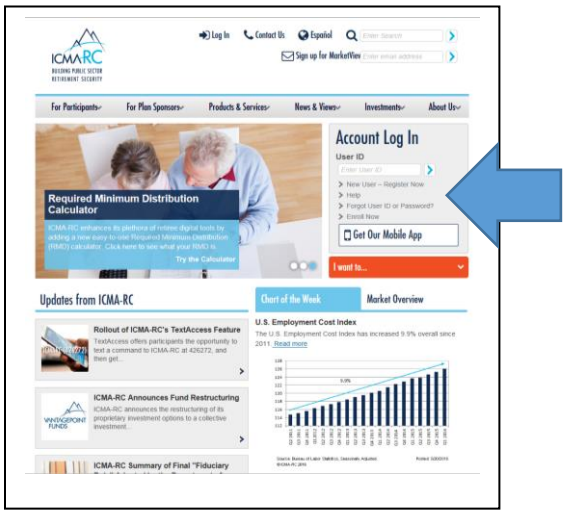
457b – In this plan, ***you*** make the deposit from your earnings. You can choose to save either a percentage of your pay or a flat dollar amount per pay. Even better, GLWA will match your contributions, dollar-for-dollar, up to three percent (3%) of your pay. GLWA's match is deposited into your 401a automatically. Registration and log-in information for this plan will be reviewed a little later in this booklet.

RHSP – Post-retirement health care coverage is a concern for many of us. While GLWA does not provide traditional retiree health care benefits, we offer assistance in paying for post-retirement health care. GLWA contributes $80 per pay, and you contribute $10 per pay into the RHSP. Once you retire, you will be able to use the funds in this plan to pay for eligible health care expenses, including your Medicare supplemental premiums.

Because these retirement plans are your plans, you have the ability to manage the investments in each of them. If you do not make your own investment choices, each plan will default into the Milestone Fund that matches your age and normal retirement date.

Within three (3) weeks after your date of hire, you will receive communications sent to your home that will let you know that ICMA-RC has established your accounts. In order to enroll, to make your 457b deferral elections and to manage your investments, you must first register with ICMA-RC (NEED TO insert link to website).

To register:



- Go to www.ICMA-RC.com and click on "New User-Register Now" in the "Account login" box;
- Follow the instructions on the registration screen (be certain to click the box that you agree to ICMA-RC's terms and conditions) then click "Next;"
- Follow the instructions to create a User ID and password, and choose your security image and questions.

Your home page will be the center for all of the functions for each of the three plans. In order to make deferral elections for tax-free contributions to the 457b plan:

- Click on the "Access My Accounts" drop-down list, and click on "My 457 Plan";
- In the upper left corner, click on the "Contributions" link.

You can elect to contribute a flat dollar amount per pay or a percentage of pay**.** Please also be certain to take the time to designate your beneficiaries. Keep in mind that you can change your deferral elections, beneficiaries or investments at any time. Please allow up to one pay period for your deferral changes to become effective.

BENEFIT TERMS YOU SHOULD KNOW

As an enrollee in GLWA benefit plans, there are a few terms that you should know.

Actively At Work – means that you are at work, on paid time away from work, and/or able to work on the date your coverage becomes effective.

Brand Name Drug – the original manufacturer's version of the medication.

- Preferred Brand – these are brand-name medications for which CVS Caremark and HAP have been able to negotiate a discount. Because the plan pays less for these medications, participants who use medications that fall into this category pay a smaller copay.
- Non-Preferred Brand – these are brand-name medications for which CVS Caremark and HAP were unable to negotiate a discount. These medications are usually first run, and there may not be

another medication on the market that treats the same condition(s). Because the plan pays more for these medications, participants who use medications that fall into this category pay a larger copay.

Coinsurance – the percentage of the cost for certain covered expenses that you pay after the deductible has been satisfied.

Copay – a flat fee that you pay toward certain covered expenses. The deductible is not applied to these types of expenses.

Deductible – the amount that you pay before the health plan will begin to pay for certain covered expenses.

Dependent – a family member who is eligible to be enrolled in your coverage. Eligible dependents include your legally married spouse, your natural and adopted children, step-children and children for whom you have guardianship.

Evidence of Good Health – this is the documentation that verifies that you and/or your dependents are in reasonable good health. This documentation is generally required when purchasing larger amounts of life insurance.

Effective Date – the date that coverage becomes effective after you have been actively employed for a specified period of time. Different benefit plans can have different effective dates.

Generic Drug – a drug that is no longer under patent and is now manufactured by more than one drug company. Although the drug is lower in cost, it is no less effective than the brand name medication.

HMO (Health Maintenance Organization) – a plan that requires ***all*** but emergency health care be performed within the approved provider network. Usually, a primary care physician (PCP) performs, coordinates and/or must approve all health care received.

In-Network – those health care providers who are participating providers of the health care plan. When you use in-network providers, your cost is less because your coinsurance is based on negotiated pricing. In-Network does not indicate geographic location.

Out-of-Network – those health care providers who are not contracted providers within the plan. If you use an out-of-network provider, you will pay a higher coinsurance amount, and you may be billed for the difference between the approved benefit and the amount billed by the provider.

Out-of-Pocket Maximum – the most you pay each plan year for eligible medical expenses. Once you or one of your enrolled dependents meets the individual out-of-pocket maximum, the plan will provide 100% coverage through the end of the plan year. The expenses that apply to the out-of-pocket maximum are, deductible, coinsurance, office visit copays and prescription drug copays.

Plan Year – the GLWA plan year is the calendar year from January through December. If you are a new employee, your plan year will begin on the effective date of your coverage and will continue through the end of that calendar year.

PPO (Preferred Provider Organization) – a plan that contracts with a network of health care providers to offer health care services at discounted prices. You have the option of receiving care within the network

or outside of the network. However, you will have higher out of pocket cost for care received outside of the network.

Pre-Tax – money that have been deferred from pay before federal, social security, state and local taxes are applied. Money that is deducted from your pay on a pre-tax basis is subtracted from your taxable earnings.

Preventive Care – health care that is designed to keep you healthy. It is medical care that you receive when you are not sick or injured. Preventive care includes, but is not limited to an annual physical, certain laboratory and x-ray screenings, well-baby care and child and adult immunizations.

Primary Care Physician – the physician who coordinates and/or provides the majority of your general health care needs. Primary care physicians (PCP) include; family practitioners, general practitioners, internists, pediatricians and gynecologists. Under an HMO, your PCP has to perform or approve health care services.

Qualified Life Event – a change in your status or the status of an eligible family member that may allow you to make changes to your healthcare and/or Flexible Spending Account enrollments. For example: marriage; the birth of a new baby or a child graduating from college.

Qualified Medical Child Support Order (QMCSO) – an order from the Friend of the Court (FOC) that requires GLWA to enroll the identified dependent in medical coverage. If the dependent is not enrolled, we will enroll the dependent in the medical plan that you have chosen. If you are not enrolled in medical coverage, we must enroll you in order to enroll your dependent. We will enroll you and your dependent in Blue Cross Blue Shield medical coverage because it is the least expensive plan.

Summary

Now that you have all of the tools necessary to make your benefit elections, go for it! You can always reach out to Dayforce Managed Services for help at any point along the way.

HOW TO GET MORE INFORMATION

For Questions About	Carrier	Call	Website/Email
Dayforce Managed Services	Ceridian	800-828-4186	mngsvcglwa@ceridian.com
Medical (PPO) Prescription Drug	Blue Cross Blue Shield of Michigan CVS Caremark	877-790-2583 800-678-0382	www.bcbsm.com www.caremark.com
Medical (HMO)	Health Alliance Plan (HAP)	800-422-4641	www.hap.org
Dental	Blue Cross Blue Shield of Michigan	877-790-2583	www.bcbsm.com
Vision	Heritage Vision Plan	800-252-2053	www.heritagevisionplans.com
Life/ADD, STD & LTD	Principal Financial	800-986-3343 Principal Absence Management: 877-734-3652	www.principal.com
Flexible Spending Accounts	Navia Benefit Solutions	800-669-3539	www.naviabenefits.com
EAP	HMSA	800-847-7240	**www.my-life-resource.com** username: hmsa password: myresource
Retirement Plans	ICMA-RC	800-669-7400	www.icmarc.org
Organizational Development		313-964-9555	OD-ALL@glwater.org

IMPORTANT NOTICES

Privacy Notice

This is to remind plan participants and beneficiaries of the GLWA Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the plan uses and discloses protected health information (PHI). You can obtain a copy of the GLWA Health and Welfare Plan Privacy Notice upon your written request to the Office of Organizational Development (OD), at the following address:

GLWA Organizational Development
735 Randolph St., 20th Floor
Detroit, MI 48226

If you have any questions, please contact GLWA OD at 313-964-9555.

Women's Health and Cancer Rights Act

Federal Law requires a group health plan or provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Newborns and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participation for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

Medicare Part D Notice of Creditable Coverage

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 the GLWA 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. GLWA has determined that the prescription drug coverage offered by the GLWA plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to 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 GLWA coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current GLWA 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 GLWA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

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; or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: September 1, 2017
Name of Entity/Sender: Great Lakes Water Authority (GLWA)
Contact: Organizational Development
Address: 735 Randolph – 20th Floor, Detroit MI 48226
Phone Number: 313-964-9555

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

Contact: GLWA Organizational Development
Address: 735 Randolph, Detroit MI 48226
Phone Number: 313-964-9555

About This Guide

This guide gives a brief overview of the benefits available to you. For plan details, including covered expenses, exclusions, and limitations, please refer to the applicable plan document for each plan. If any discrepancy exists between this guide and the plan document(s), the plan document(s) will govern. GLWA reserves the right to make changes at any time.

GLWA
Great Lakes Water Authority