2023

Employee Benefits Overview

SAN BERNARDINO MUNICIPAL WATER DEPARTMENT

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on Pages 31-32 for more details.

Benefits Overview

At the San Bernardino Municipal Water Department, we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

OPEN ENROLLMENT UPDATES:

- San Bernardino Municipal Water Department is pleased to announce that there will not be any changes to the plans this year.
- Please pay close attention to the login instructions for BenXcel's portal on page 7.

A pre-recorded presentation providing a broad explanation of 2023 benefits is available by clicking the link below:

https://www.brainshark.com/alliant/SBWMD_2023ActiveOE

The benefits in this summary are effective:

January 1, 2023 - December 31, 2023

DISCLAIMER
The information in this brochure is a general outline of the benefits offered under the San Bernardino Municipal Water Department benefits program. This brochure may not include all relevant limitations and conditions. Specific details and limitations are provided in the plan documents, which may include a Summary Plan Description (SPD), Evidence of Coverage (EOC), and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this brochure differs from the plan documents, the plan documents will prevail.

Open Enrollment

Open Enrollment is your once-a-year opportunity to elect, change, cancel your benefits coverage, or add/drop dependent coverage. Here is some important information regarding this year's Open Enrollment:

Please consider your options carefully because you may only make changes to your benefit elections during Open Enrollment, or if you experience a mid-year "qualified status change". All Open Enrollment benefit changes will be effective **January 1, 2023**.

Open Enrollment is October 10 through October 21, 2022

All enrollments must be completed in the Benefit Coordinators Corporation (BCC) system prior to October 21st at 3:00pm. If you have any questions please contact BCC Customer Service at (855) 230-0745 Ext. 6414.

It is recommended that all employees verify their information in the BCC system even if they are not making any changes. See page 8 for instructions on using the BCC on-line system.

Key Points to Keep In Mind

- Employees currently enrolled in the Flexible Spending Account (FSA), must re-enroll for the 2023 plan year. FSA enrollment does not automatically roll over to the new plan year. **If you are currently enrolled in the FSA plan and re-enroll for the 2023 plan year, you will not receive a new debit card.**
- The Social Security Number field is mandatory for employees and dependents.
- Opt-Out Benefits Program:
    - Employees who opt-out or "waive" medical coverage must provide proof of other medical coverage each year and/or within 30 days of a qualified status change to "waive" coverage.
- If you do not make any changes to your medical, dental, or vision benefits, you will automatically be enrolled in your current benefits for the 2023 plan year.

Rules For Benefit Changes During The Year

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualifying status change or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by your spouse, or your dependent child
- **Change in work schedule**, including an increase or decrease in hours of employment by your spouse, or your dependent child; or a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite**, including a change that affects the accessibility of network providers
- **Change in your health coverage or your spouse's coverage**, attributable to your spouse's employment
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA),** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have 60 days after the following events to request enrollment:
    - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
    - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Two rules apply to making changes to your benefits during the year:

- **Any changes you make must be consistent with the change in status, AND**
- **You must make the changes within 30 days of the date the event (marriage, birth, etc.) occurs (unless otherwise noted above).**

Please note the following effective dates in regard to Qualifying Events:

- **Adds, terms and changes are effective First of the Following Month of the event. There are two exceptions**
    - **Birth of a child – added on date of birth**
    - **Death of a Member – term the day after death**

Who Can You Cover?

WHO IS ELIGIBLE?

In general, regular full-time employees working 30 or more hours per week are eligible for the benefits outlined in this overview. In order to comply with the Affordable Care Act (ACA), San Bernardino Municipal Water Department generally determines your eligibility for benefits based using the Look-Back Measurement Method. Refer to the Look-Back Measurement Method section of this guide for additional information on how your eligibility is determined.

You can enroll the following family members in our medical, dental and vision plans.

- Your legal spouse. Proof of marriage certificate and Social Security Number are required.
- Your domestic partner. Must be registered with the California State Registry and at least 18 years of age. Proof of domestic partnership and Social Security Number are required. Premiums for domestic partnership are based on imputed tax. Please consult with a tax advisor for further information.
- Your or your domestic partner's natural children, stepchildren, adopted children and/or children of which the employee or domestic partner is the legal guardian. Proof of birth certificate and Social Security Number are required. In addition, dependent children must meet the following age requirements:
  - Dependents are eligible up to age 26 for Medical, Dental, and Vision insurance.
- Your physically or mentally handicapped children who meet the plan eligibility guidelines and depend on you for support, regardless of age.

Note: You must provide proof of dependency (i.e. copy of marriage certificate, birth certificate, domestic partnership registration, etc.) within 30 days of enrolling dependents in a plan.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of San Bernardino Municipal Water Department cannot also be covered as a dependent.
- Employees who work fewer than 30 hours per week, temporary employees, contract employees, or employees residing outside the United States.

ENROLLMENT PERIODS

Coverage for new employees begins on the 1st of Month Following Date of Hire.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Notify Human Resources within 30 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Note: It is the responsibility of the employee to enroll in the plan prior to completion of the eligibility period. Any employee who declines coverage or does not enroll within 30 days of hire will not have the option to enroll or receive a Department contribution until Open Enrollment unless the employee experiences a qualified status change.

Benefits At A Glance

Benefits	Who Pays	When Benefit Begins	When Benefit Ends
Medical	You and SBMWD	First day of the month following date of hire (must enroll within 30 days of hire)	Last day of the month in which you terminate employment or a qualifying event occurs
Dental			
Vision			
Basic Life Insurance	SBMWD	First day of the month following date of hire (must enroll within 30 days of hire)	Last day of employment
Accidental Death & Dismemberment Insurance			
Supplemental Life and AD&D Insurance	You	First day of the month following date of hire (must enroll within 30 days of hire)	Last day of employment
Short Term Disability	SBMWD	First day of the month following date of hire	Last day of employment
Long Term Disability			
Flexible Spending Account	You	First day of the month following date of hire (must enroll within 30 days of hire)	Last day of employment
Pet Program	You	First day of the month following date of hire	Last day of the month in which you terminate employment
Employee Assistance Program	SBMWD	First day of employment	Last day of employment

Open Enrollment Login Instructions

WELCOME TO BENXCEL 2.0

These instructions will help you to complete your Open Enrollment benefit elections for the 2023 Plan Year (January 1, 2023 – December 31, 2023) through BenXcel 2.0.

- Open Enrollment Period: **October 10th, 2022, at 12 am PT through October 21st, 2022.**

LOG IN INSTRUCTIONS

Sign In

User Name

Password

Company Name

SIGN IN

Forgot Password?

1. To log into BenXcel, go to: https://benxcel.net
2. Enter your username: The first 4 letters of your last name and last 4 digits of SSN. *(Ex: Mickey Mouse SSN: 123456789 would be- mous5678)*
3. Enter your initial password: The first 4 letters of your last name and first 4 digits of SSN *(ex: mous1234)*
4. Enter the Company Name: SBMWD
5. Click the Sign In button to enter the system

ENROLLMENT PROCESS

1. Required Employee Usage Agreement, Legal Agreement, and an Open Enrollment Welcome screens will appear. Review the messages and click the Continue button to proceed.

2. For security purposes, you will be forced to change your password immediately. A Change Password screen will appear requiring you to
    - Choose two security questions and enter your answers in the Secret Answer fields.
    - Change your password. Click the Save button when finished.

Change Password

Instructions
- Password must contain at least one letter
- Password must contain at least one uppercase character
- Password must contain at least one number
- Password must contain at least one special character.
- Password must be of EXACT length 8 Characters.

Security Question 1 *

--Select Security Question--

Answer 1 *

Security Question 2 *

--Select Security Question--

Answer 2 *

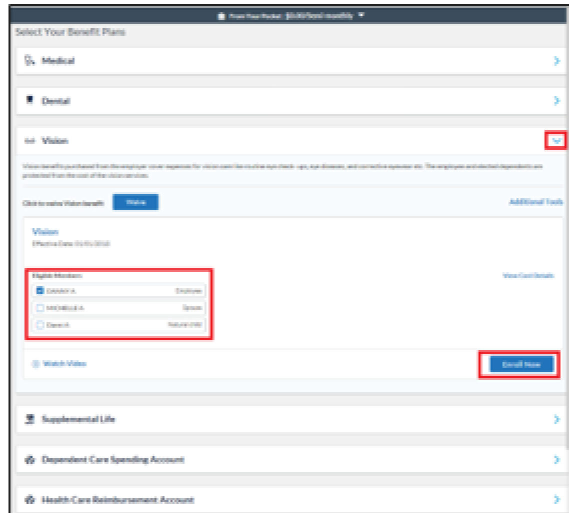
New Password *

Confirm Password *

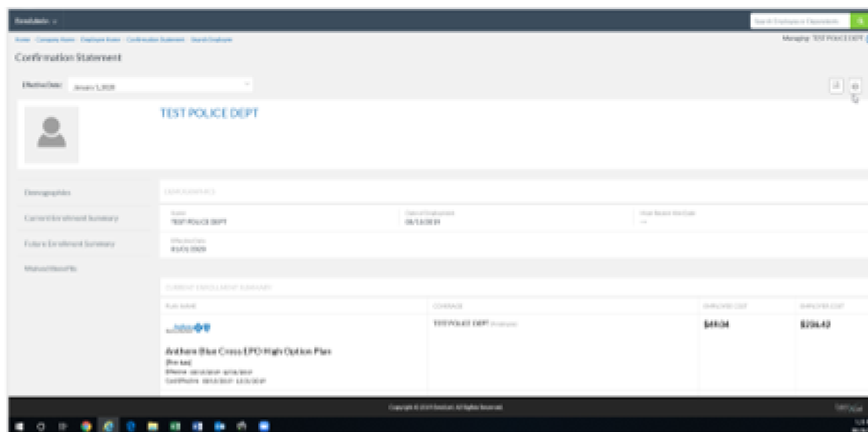
Back | Reset | Save & Continue

3. A Demographics page will appear for you to review your existing information.
    - Click the Save button to proceed.

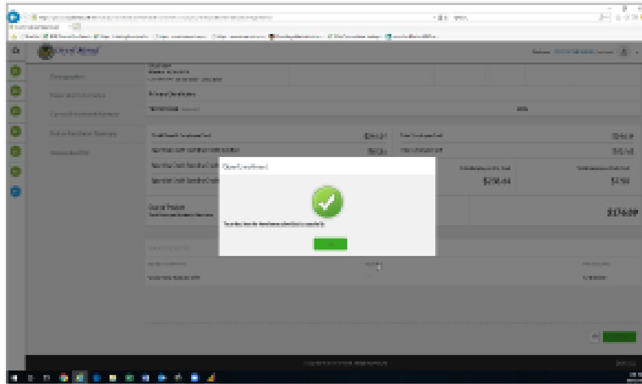
4. A Spouse or Domestic Partner and a Dependent Child screen will appear for you to review any existing information, the history of all your dependents will appear on this screen. You can add a new spouse, domestic partner, and/or dependent(s), or terminate an existing spouse, domestic partner, and/or dependent(s).
   - Click the Continue button to proceed.
5. Your enrollment will now begin. You will be walked through a series of benefit screens, presenting only the benefits available to you.
6. If the benefit is waivable, a Waive button will appear. Click to waive the benefit.
   - In the 'Eligible Members' box, check/uncheck the box next to each member's name to indicate who should and should not be covered under this benefit.
   - A description of each benefit is included on each benefit enrollment screen. Click on Benefit Description, then click on the plan document you wish to review.
   - If Evidence of Insurability (EOI) is required for an election, it will appear as a pop-up with a link to the EOI form. You must complete and follow the instructions to submit.



7. Click the Enroll Now button to choose a Plan. The next benefit available will automatically appear.
8. An Election Summary along the top of the screen will continually update with elections and costs as you continue through your enrollment. If you log out of the system at any time without finishing your enrollment, the system will save all elections made prior to you logging out.
9. A Confirmation Statement will appear when the enrollment is complete. This Statement will show your demographic information, current enrollment summary (2022) benefit elections, and all future enrollment summary (2023) benefit elections. The Confirmation Statement can be printed or downloaded as a PDF by using the print/pdf icons at the top right corner of the Statement. Please see the screen print below.



10. **Click the Finish button to save and submit the 2023 Benefit Elections.**
11. A pop up will appear that your enrollment is complete and then your dashboard will appear.



12. A countdown will appear at the top right corner of your dashboard, notifying you of the amount of time remaining to make Open Enrollment benefit elections. The countdown acts as a link to return to the enrollment to make changes.

13. Once satisfied with your elections, log out of BenXcel by clicking your Name then “Log Out” at the top right corner of your screen. You may log back in at any time during SBMWD’s Open Enrollment period to make changes to your elections by clicking on the prompt below.

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if you are familiar with the most common terms.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Medical – HMO

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

The HMO plans offer comprehensive coverage and a broad network of physicians and hospitals to choose from. Care is coordinated through each member's Primary Care Physician (PCP). Below are the HMO plans available to you.

	Kaiser (PRISM) HMO	Anthem (PRISM) Premier HMO
	In-Network	In-Network
Annual Deductible	None	None
Annual Out-of-Pocket Max	$1,500 per individual $3,000 family limit	$1,500 per individual $3,000 family limit
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$20 copay	$20 copay
Specialist	$20 copay	$20 copay
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic Care	$15 copay (up to 20 visits per calendar year)	$20 copay (60 day limit per benefit period for Physical, Occupational, and Speech Therapy combined)
Lab and X-ray	Plan pays 100%	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%
Outpatient Surgery	$20 copay per procedure	Plan pays 100%
Urgent Care	$20 copay	$20 copay
Emergency Room	$50 copay per visit (copay waived if admitted)	$50 copay (copay waived if admitted)

Prescription Drugs - HMO

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our HMO medical plans.

	Kaiser (PRISM) HMO		Anthem (PRISM) Premier HMO
	In-Network		In-Network
Prescription Drug Deductible	None	**Prescription Drug Deductible**	None
Annual Out-of-Pocket Limit	Combined with Medical	**Annual Out-of-Pocket Limit**	Combined with Medical
Pharmacy		**Pharmacy**	
Generic	$10 copay	Tier 1	$10 copay
Preferred Brand	$30 copay	Tier 2[1]	$30 copay
Non-preferred Brand	$30 copay	Tier 3[1]	$45 copay
Supply Limit	30 days	Supply Limit	30 days
Mail Order		**Mail Order**	
Generic	$20 copay	Tier 1	$20 copay
Preferred Brand	$60 copay	Tier 2[1]	$60 copay
Non-preferred Brand	$60 copay	Tier 3[1]	$90 copay
Supply Limit	100 days	Supply Limit	90 days

[1]If a member requests a brand name or non-formulary drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed charge for the generic drug and the brand name drug.

Medical – PPO

The PPO plan provides choice and flexibility. Participants can choose an in-network provider or go to an out-of-network provider at a higher cost. There are annual deductibles before benefits apply and you are responsible for copays and co-insurance. Service from Non-PPO providers may have lower benefits and be subject to balance billing.

	Anthem (PRISM) Classic PPO	
	In-Network	**Out-Of-Network**
Annual Deductible	$500 per individual $1,000 family limit	$500 per individual (combined with in-network) $1,000 family limit (combined with in-network)
Annual Out-of-Pocket Max	$2,000 per individual $4,000 family limit	$2,000 per individual (combined with in-network) $4,000 family limit (combined with in-network)
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$20 copay[1]	Plan pays 60% after deductible
Specialist	$20 copay[1]	Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Chiropractic Care	$20 copay[1] (up to 30 visits per year)	Plan pays 60% after deductible (in-network limitations apply)
Lab and X-ray	Plan pays 90% after deductible	Plan pays 60% after deductible (complex imaging: up to $800 per test; all other: up to $350 per day)
Inpatient Hospitalization	Plan pays 90% after deductible	$250 admission copay then plan pays 60%[2] after deductible (up to $600 per day)
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 60% after deductible (up to $350 per day)
Urgent Care (cost may vary by site)	$20 copay[1]	Plan pays 60% after deductible
Emergency Room	$50 copay then plan pays 90% after deductible (copay waived if admitted)	$50 copay then plan pays 90% after deductible (copay waived if admitted)

[1] Deductible waived. Deductible does not apply to in-network providers.

[2] $500 additional copay if you do not receive preauthorization for non-emergency services at an Out-of-Network Provider.

Prescription Drugs - PPO

Here is the prescription drug benefit that is included with our PPO medical plan.

	Anthem (PRISM) Classic PPO	
	In-Network	**Out-Of-Network**
Prescription Drug Deductible	None	None
Annual Out-of-Pocket Limit	$5,350 per individual $10,700 per family	Non-Network claims do not apply to the Out-of-Pocket limit
Pharmacy		
Tier 1	$10 copay	$10 copay
Tier 2[1]	$20 copay	$20 copay
Tier 3[1]	$35 copay	$35 copay
Supply Limit	30 days	30 days
Mail Order		
Tier 1	$15 copay	Not covered
Tier 2[1]	$30 copay	Not covered
Tier 3[1]	$50 copay	Not covered
Supply Limit	90 days	Not applicable

[1]If a member requests a brand name formulary or non-formulary drug when a generic drug exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed charge for the generic drug and the brand name drug.

Getting Care When You Need It Now

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

Kaiser Permanente Plan Participants

- Call 24/7 Care Advice at 833-574-2273
- Find an urgent care center by visiting kp.org/getcare
- Telephone appointments at 833-574-2273

Anthem Medical Plan Participants

- Find an urgent care center by visiting anthem.com/ca
- Use Anthem's LiveHealth Online
- Chat with a Behavioral Health Specialist on LiveHealth Online
- Call Anthem's 24/7 Nurseline at 800-337-4770

GET A VIDEO HOUSE CALL

Anthem members can video chat with a doctor from the comfort of their own homes, without an appointment. LiveHealth Online provides 24/7 access to U.S. board-certified physicians, for $59 or less depending on your plan. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. In addition to medical providers, you can now also speak with a Behavioral Health Specialist. For more information, visit livehealthonline.com.

Kaiser members can schedule a video visit by calling 833-574-2273. You can also schedule some appointments online at kp.org/getcare or with the Kaiser Permanente app. Meet face-to-face online with a clinician on your computer, smartphone or tablet for minor conditions or follow-up care.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through EyeMed Vision Care.

EyeMed Vision Plan

	In-Network	Out-Of-Network
Examination		
Benefit	$10 copay	Up to $49 Allowance
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Materials	$10 copay	See Schedule Below
Eyeglass Lenses		
Single Vision Lens	$10 copay	Up to $35 Allowance
Bifocal Lens	$10 copay	Up to $49 Allowance
Trifocal Lens	$10 copay	Up to $74 Allowance
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Frames		
Benefit	Up to $130 Allowance + 20% Off Retail Price Over $130	Up to $60 Allowance
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Contacts (Elective) (in lieu of glasses)		
Benefit	Up to $130 Allowance + 15% Off Retail Price Over $130 (conventional lenses)	Up to $104 Allowance
Frequency	1 x every 12 months from last date of service	In-network limitations apply

Note: Benefits are based on a 12 month service year, not a calendar year. This means that you are not eligible for another exam or new lenses or contacts until at least 12 months have passed since you last received services. You are not eligible for new frames until 12 months have passed from the last date of service.

Dental - PPO

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

San Bernardino Municipal Water Department provides you with a comprehensive coverage through Delta Dental of California.

	Delta Dental (PRISM) Dental PPO – Core Plan		**Delta Dental (PRISM) Dental PPO – Buy Up Plan**	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Calendar Year Deductible	$50 per person	$50 per person	$50 per person	$50 per person
Annual Plan Maximum	$1,000	$1,000	$1,500	$1,500
Diagnostic and Preventive[1]	Plan pays 100%	Plan pays 80%	Plan pays 100%	Plan pays 80%
Basic Services				
Fillings	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Root Canals	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontic Services				
Orthodontia	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
Lifetime Maximum	$2,000 lifetime per person	$2,000 lifetime per person	$2,000 lifetime per person	$2,000 lifetime per person
Children to age 18	Covered	Covered	Covered	Covered
Adults	Covered	Covered	Covered	Covered

[1] Deductible is waived for Diagnostic & Preventive (D&P) and Orthodontics.

Dental - HMO

Here is an overview of our third dental plan, a HMO plan offered through Delta Dental of California. This plan works like the medical HMO and care is coordinated through an assigned primary care provider. The plan offers the convenience of scheduled copays for specific procedures with no deductible or annual maximum.

	DeltaCare HMO (PRISM)
	In-Network only
Calendar Year Deductible	None
Annual Plan Maximum	Unlimited
Diagnostic and Preventive	$0 - $45 copay (refer to Patient Charge Schedule for applicable copay)
Basic Services	
Fillings	$0 - $110 copay (refer to Patient Charge Schedule for applicable copay)
Root Canals	$0 - $280 copay (refer to Patient Charge Schedule for applicable copay)
Periodontics	$0 - $280 copay (refer to Patient Charge Schedule for applicable copay)
Major Services	$25 - $240 copay (refer to Patient Charge Schedule for applicable copay)
Orthodontic Services	
Orthodontia	$1,700 – child to age 19 $1,900 - adult
Lifetime Maximum	Unlimited
Adult & Dependent Children	Covered

Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

BASIC LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the company. Coverage is provided by PRISM Voya Financial. **This insurance coverage is provided at no charge to the employee.**

Unit	Basic Life Amount	AD&D Amount	Dependent Coverage
General	$35,000	$20,000	$1,000
Mid - Management	$50,000	$25,000	$1,000
Management / Confidential	$50,000	$50,000	$1,000
Board Members	$50,000	$50,000	$1,000

VOLUNTARY LIFE AND AD&D

You may purchase supplemental Voluntary Life and AD&D coverage for yourself through PRISM Voya Financial. The Voluntary Life minimum benefit is the greater of 1x annual salary or $10,000 to a maximum of 5x annual salary up to $700,000 and is purchased in increments of 1x annual salary.

Voluntary AD&D can be purchased in amounts of $25,000; $50,000; $75,000; $100,000; $150,000; $200,000; or $250,000.

The Voluntary Life and AD&D benefits can be purchased separately or combined. Changes in Voluntary Life and/or AD&D benefits or new enrollments can be completed using the BCC online system or by calling BCC Customer Service.

Any changes to your Voluntary Life benefit/coverage will require completion and submittal of an Evidence of Insurability (EOI) form.

Premiums will be deducted from your paycheck.

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

SHORT TERM DISABILITY (STD)

All active eligible employees are covered under the Short Term Disability (STD) plan through PRISM Voya Financial. The STD plan provides you with income replacement when illness or injury makes it impossible for you to work for a short period of time. STD income benefit will be reduced by other deductible sources of income.

Contact Human Resources for complete information on eligibility, elimination periods, maximum benefits and benefit duration.

This insurance coverage is provided at no charge to the employee.

LONG TERM DISABILITY (LTD)

All active eligible employees are covered under the Long Term Disability (LTD) plan through PRISM Voya Financial. The LTD plan provides you with income replacement when non-work related illness or injury make it impossible for you to work for an extended period of time. The benefit may be paid up to normal retirement and is reduced by other deductible sources of income.

Contact Human Resources for complete information on eligibility, elimination periods, maximum benefits and benefit duration.

This insurance coverage is provided at no charge to the employee.

Voluntary Pet Program

United Pet Care

San Bernardino Municipal Water Department is pleased to offer you the opportunity to elect a voluntary pet care plan through United Pet Care. This program includes preventive, accident, and sick care. Members receive instant savings of 20-50% off veterinary visits. United Pet Care features no claim forms, no costly deductibles, no waiting period, no age exclusions, and no exclusions due to pre-existing or breed specific conditions. All pets are eligible!

Follow these simple steps:

1. Enter your contact information and select a password
2. Select "YES" when asked if you are enrolling through a benefits program
3. Enter "SBMWD" when asked to select your employer
4. Enter your employee ID number
5. Add pets to be covered
6. Select a Vet (search using zip code). You are required to select a veterinary clinic in the network to access your pet's care. Click on the selected clinic once you have decided.
7. Review information and edit as necessary and approve

Monthly premiums:

1 pet - $17.50
Each Additional Pet - $16.50

Premiums are paid through the convenience of payroll deductions. You can take this coverage with you and be direct billed for the individual pricing plan if your employment status changes.

Please Note: This plan requires a 1- year membership. If at any time you would like to cancel, you must contact United Pet Care directly at (888)781-6622. Member ship is effective for 1 year from the effective date of the coverage unless you no longer own the pet, or the pet has passed.

Flexible Spending Account

Do you have out-of-pocket expenses for medical co-pays, deductibles, dental/vision expenses throughout the year? Do you have day care expenses?

A great way to save money over the course of a year is by participating in the Flexible Spending Accounts (FSAs). These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible medical and dependent care expenses.

Pre-tax means the dollars you use for eligible expenses are not subject to social security tax, federal income tax and, in most cases, state and local taxes. Money you would have normally paid in taxes, can now be used to pay for your qualified medical and dependent care expenses.

You may enroll in the San Bernardino Municipal Water Department FSA sponsored plan even if you receive health care insurance through your spouse's employer. In addition, the FSA can be used for eligible expenses for all your qualified dependents.

Health Care Spending Account
This account will reimburse you with pre-tax dollars for health care expenses not reimbursed under your family's health care plans. **You can now elect to contribute up to $2,850 maximum annually for the Health Care Reimbursement Account.**

Dependent Care Spending Account
This account will reimburse you with pre-tax dollars for day care expenses for your child(ren). **The maximum amount you may contribute to a Dependent Care Spending Account is $5,000 a year or $2,500 if you are married and file separate tax returns.**

Eligible Dependents for Dependent Care Spending Accounts Include:

- Children under the age of 13 who you have primary custody of; and
- Children of any age who are physically or mentally unable to care for themselves and who qualify. You may use the federal childcare tax credit and the Dependent Care Spending Account; however, your federal credit will be offset by any amount deferred into dependent care plan.

How Your FSA Account Works
Each year during the Open Enrollment period, you decide how much you want to contribute to the Healthcare and Dependent Care Spending Accounts. Each pay period, the money is deducted before taxes, in equal increments, from your pay and contributed to your healthcare and / or dependent care spending account(s).

Be Cautious!!

- Only qualifying medical and dependent care expenses incurred during the plan year will be eligible for reimbursement. You may incur eligible expenses from January 1, 2023 through March 15, 2023.
- Use it or lose it! Money in the accounts must be claimed by March 31, 2023 after the end of the plan year or it will be subject to the "use-it-or-lose it" rule and will be forfeited.
- Once you enroll, you can only change your elected payroll deduction if there is a change in family status, such as: Marriage, Divorce, Death, Birth, Adoption, or Change in Employment Status.
- Money cannot be transferred between the Health Care and Dependent Care FSA.
- If you are no longer working for the San Bernardino Municipal Water Department, you can continue to submit requests for expenses incurred up to and including your date of separation. The filing deadline to submit claims is March 31, 2023.

Employee Assistance Program

The Employee Assistance Program (EAP) benefit is offered through The Counseling Team International (TCTI). Just when you think you have it figured out, along comes a challenge. But whether those challenges are big or small, your EAP is available to help you and your family find a solution and restore your peace of mind. The EAP provides face to face visits and can refer you to professional counselors and services that can help you resolve emotional health, family and work related issues. Assistance is available 24-hours a day.

You can call TCTI or go online, search the provider directory and request a referral.

Call to get the assistance you need to help resolve life's challenges:

(800) 222-9691

Or visit the website at www.thecounselingteam.com

This insurance coverage is provided at no charge to the employee.

Cost of Coverage

Anthem Premier HMO - Medical	Cost
Employee Only	$693.50
Employee + 1	$1,378.50
Employee + 2 or More	$1,849.50

Anthem Classic PPO - Medical	Cost
Employee Only	$970.50
Employee + 1	$1,928.50
Employee + 2 or More	$2,589.50

Kaiser Permanente HMO - Medical	Cost
Employee Only	$618.50
Employee + 1	$1,228.50
Employee + 2 or More	$1,647.50

Delta Dental HMO - Dental	Cost
Employee Only	$16.80
Employee + 1	$29.90
Employee + 2 or More	$43.80

Delta Dental PPO Core Plan - Dental	Cost
Employee Only	$35.10
Employee + 1	$75.80
Employee + 2 or More	$103.50

Delta Dental PPO Buy Up Plan - Dental	Cost
Employee Only	$40.80
Employee + 1	$88.40
Employee + 2 or More	$120.80

EyeMed Vision PPO - Vision	Cost
Employee Only	$6.13
Employee + 1	$11.58
Employee + 2 or More	$16.96

The costs above do not reflect the Department contribution amounts. Please refer to page 26 for the 2023 contribution amounts. Please call SBMWD Human Resources at (909) 453-6091 if you have any questions.

Note: Your medical, dental, and vision contributions will be made through payroll deductions and paid on a pre-tax basis. That is, you do not pay taxes on the portion of your income that goes toward your benefit premiums. If you do not want your contributions deducted on a pre-tax basis, please notify Human Resources.

Department Contributions

Monthly Department Contributions	Cost
Employee Only	$766.00
Employee + 1	$1,409.00
Employee + 2 or More	$1,815.00

The SBMWD contributions cannot be used to pay for voluntary deductions, such as life insurance.

Look-Back Measurement Method

You and your dependents are eligible for the medical plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours or more per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. ACA full-time status can affect or determine medical benefits eligibility but is not a guarantee of benefits eligibility. San Bernardino Municipal Water Department uses the Look-Back Measurement Method to determine whether an employee meets this eligibility threshold.

NEW EMPLOYEES

New employees hired to work full-time

If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for Anthem or Kaiser's health plan coverage as of the 1st day of the month following date of hire.

New employees hired to work a variable hour or seasonal schedule

If you are hired into a part-time position, a position where your hours vary and San Bernardino Municipal Water Department is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee.

Your 12-month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average 30 or more hours a week over that 12-month period, you will be considered full time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends.

Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES

San Bernardino Municipal Water Department uses the look-back measurement method to determine Anthem and Kaiser's group health plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which San Bernardino Municipal Water Department counts employee hours to determine which employees work full-time.

An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be considered full-time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect for a 12-month stability period.

If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

San Bernardino Municipal Water Department uses the standard measurement period and associated stability period annual cycle set forth below.

Measurement Period: Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility	November 1 – October 31
Stability Period: Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period	January 1 – December 31

Important Plan Notices and Documents

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the Insurance Carriers' HIPAA Privacy Notices. You can request copies of the Privacy Notices by contacting the Human Resources Department or by contacting the insurance carriers directly.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights for coverage to be provided in a manner determined in consultation with the attending Physician for:

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

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical procedures provided under this plan. You can contact your health plan's Member Services for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in Public Risk Innovation, Solutions, and Management's (PRISM) health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Public Risk Innovation, Solutions, and Management's (PRISM) health plan without waiting for the next open enrollment period if you:

•Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.

•Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request [medical plan OR health plan] enrollment within [30/31] days after the marriage, birth, adoption, or placement for adoption.

•Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the [30/31] day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following the qualifying event. In addition, you may enroll in Public Risk Innovation, Solutions, and Management's (PRISM) medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

NOTICE OF CHOICE OF PROVIDERS

Public Risk Innovation, Solutions, and Management (PRISM) generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your plan administrator.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Public Risk Innovation, Solutions, and Management (PRISM) or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your plan administrator.

ACA 1557 Notice

Nondiscrimination statement for significant publications and signification communications:

Public Risk Innovation, Solutions, and Management complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Medicare Part D Notice

Important Notice from Public Risk Innovation, Solutions, and Management (PRISM) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Public Risk Innovation, Solutions, and Management's (PRISM) 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. Your plan has determined that the prescription drug coverage offered by PRISM 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 Public Risk Innovation, Solutions, and Management (PRISM) coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Public Risk Innovation, Solutions, and Management (PRISM) is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Public Risk Innovation, Solutions, and Management (PRISM) prescription drug coverage, be aware that you and your dependents may 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 Public Risk Innovation, Solutions, and Management (PRISM) 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 Your Options under Medicare 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 Public Risk Innovation, Solutions, and Management (PRISM) 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 **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 800-MEDICARE (800-633-4227). TTY users should call 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 **socialsecurity.gov**, or call them at 800-772-1213 (TTY 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: January 1, 2023
Name of Entity/Sender: San Bernardino Municipal Water Department
Contact-Position/Office: Human Resources
Address: 1350 S. E Street, Building B, San Bernardino, CA 92408
Phone Number: (909) 453-6091

Plan Contacts

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	Kaiser HMO	800-464-4000	www.kp.org	232111
Medical	Anthem Premier HMO	800-967-3015	www.anthem.com/ca/prism	175075
Medical	Anthem Classic PPO	800-967-3015	www.anthem.com/ca/prism	175075
Medical	Express Scripts (PPO only)	877-554-3091	www.express-scripts.com	175075Q001
Dental	Delta Dental PPO	888-335-8227	www.deltadentalins.com	17497
Dental	DeltaCare HMO	800-422-4234	www.deltadentalins.com	19749
Vision	EyeMed	866-939-3633	www.eyemedvisioncare.com	9928466
Life and AD&D STD and LTD	Voya Financial	888-305-0602	www.voya.com	316407
Employee Assistance Program (EAP)	The Counseling Team International	800-222-9691 909-884-0133	www.thecounselingteam.com	N/A
Pet Program	United Pet Care	888-781-6622	www.unitedpetcare.com/sbmwd	N/A
Flexible Spending Account (FSA)	Benefits Coordinators Corporation	855-230-0745 Ext. 6414	https://benxcel.net	N/A
COBRA Administration	Benefits Coordinators Corporation	855-230-0745 Ext. 6414	https://benxcel.net	N/A
Enrollment & Call Center for Active Employees	Benefits Coordinators Corporation	855-230-0745 Ext. 6414	https://benxcel.net	N/A
San Bernardino Municipal Water Department	Human Resources	909-453-6091	www.sbmwd.org	N/A
Deferred Compensation Section 457 Plan	Empower	800-743-5274	www.retiresmart.com	63122

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