2023

Early Retiree 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 15-16 for more details.

Benefits Overview

Dear Valued San Bernardino Municipal Water Department retiree:

The San Bernardino Municipal Water Department (SBMWD) offers retirees an option to purchase medical insurance at lower group rates through Department sponsored plans. This medical program provides flexibility for the diverse and changing needs of our retirees. The goal is to provide you with affordable quality health care benefits.

Monthly premium rates can be found on Page 11. Your Department Contribution amount can be found on the enclosed 2023 Contribution memo. Once again, we are pleased to offer valuable benefits to our retirees.

San Bernardino Municipal Water Department is pleased to announce that there will not be any changes to the plans this year.

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

https://www.brainshark.com/alliant/SBWMD_2023EarlyRetireeOE

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.**

2023 Offerings:

- Kaiser Permanente Medical HMO (PRISM)
- Anthem Blue Cross Medical Premier HMO (PRISM)
- Anthem Blue Cross Medical Classic PPO (PRISM)

Retiree Billing

Benefit Coordinators Corporation (BCC) will continue as the administrator who will be managing the retiree billing and eligibility. If you have questions, please call (855) 230-0745 Ext. 6414.

Open Enrollment is October 10 through October 21, 2022

All enrollment and/or changes must be completed by contacting BCC Customer Service at (855) 230-0745 Ext. 6414 prior to October 21 at 3:00pm (PST). No action is required if you are not making any changes to your current medical plan.

If you have any questions regarding enrollment or plan changes, please contact BCC Customer Service at the number above.

Eligibility For Benefits

Retiree Eligibility

After your initial enrollment, unless you qualify for a "special enrollment", you cannot make changes in your election until the next "open enrollment". Please see Page 6 for "special enrollment" qualifications. You are allowed to terminate your coverage at any time during the year by submitting a written request to SBMWD; however, once you have submitted this request, there will be no reinstatement.

Dependent Eligibility

- 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.
- 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.
  - ⇒ Your physically or mentally handicapped children who meet the plan eligibility guidelines and depend on you for support, regardless of age.

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.

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.

<u>**Two rules apply to making changes to your benefits during the year:**</u>

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

<u>**Please note the following effective dates in regard to Qualifying Events:**</u>

- **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**

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 plan offers 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 (Early Retirees)	**Anthem (PRISM) Premier HMO (Early Retirees)**
	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	Plan pays 100%
Urgent Care	$20 copay	$20 copay
Emergency Room	$50 copay (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 (Early Retirees)		Anthem (PRISM) Premier HMO (Early Retirees)
	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
(Early Retirees)

	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 procedure; all other: up to $350 per visit)
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 deductible for non-Anthem PPO hospital if utilization review not obtained

Prescription Drugs - PPO

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

	Anthem (PRISM) Classic PPO (Early Retirees)	
	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.

2023 Monthly Medical Premiums

Rates do not include contribution amounts. Please refer to your Open Enrollment memo or contact Human Resources at (909) 453-6091 for 2023 contribution amounts and questions.

Early Retiree (Retiree under age 65) & Retiree 65+ WITHOUT Medicare	
Anthem HMO	
Employee Only	$693.50
Employee + Spouse	$1,378.50
Employee + Family	$1,849.50
Kaiser HMO	
Employee Only	$618.50
Employee + Spouse	$1,228.50
Employee + Family	$1,647.50
Anthem Classic PPO	
Employee Only	$970.50
Employee + Spouse	$1,928.50
Employee + Family	$2,589.50

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 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 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.

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

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
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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.

Plan Contacts

If you need to reach our plan providers, here is their contact information:

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	175075Q002 – PPO 175075Q004 – Medicare PPO Supplement
Billing & Eligibility	Benefit Coordinators Corporation (BCC)	855-230-0745 Ext. 6414	N/A	N/A
457 Deferred Compensation	Empower	800-743-5274	www.retiresmart.com	63122
Water Human Resources Dept	Human Resources	909-453-6091	www.sbmwd.org	N/A

Notes

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