

2026



Active Employee Benefits Overview

Make The Most of Your Benefits



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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 Important Plan Information section for more details.



Welcome to Your Benefits Guide

The benefits in this summary are effective
January 1, 2026 through **December 31, 2026**

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, San Bernadino Municipal Water Department supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

A pre-recorded presentation providing a broad explanation of 2026 benefits is available by clicking the link below: <https://www.brainshark.com/alliant/2026sbmwdoe>



IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents 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, 2026**.

Open Enrollment is October 6, 2025 through October 17, 2025.

All enrollments must be completed in the Benefit Coordinators Corporation (BCC) system prior to October 17th 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 2026 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 2026 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 2025 plan year.

What's New?

Introducing Navitus Pharmacy Benefits - Navitus is replacing Express Scripts (ESI) for prescription drugs benefits beginning 01/01/2026. See page 15 for more information.

Introducing Digbi Health - Eligible Anthem members can enroll in Digbi Health, a highly personalized program that helps manage obesity, diabetes, cardiometabolic conditions, and digestive health beginning 01/01/2026. See page 14 for more information.

Who is Eligible?

You are eligible if you are a regular full time employee working 30 or more hours per week.

The following dependents are eligible for benefits:

- Legally married spouse.
- 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.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

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 Bernadino Municipal Water Department cannot also be covered as a dependent.
- Employees who work less than 30 hours per week, temporary employees not on San Bernadino Municipal Water Department payroll, contract employees, or employees residing outside the United States.



When you can enroll

New Hire Enrollment	New hire coverage begins first of the month following date of hire. You must enroll within 30 days of becoming eligible.
Open Enrollment	The one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in October every year for a January 1 effective date.
Qualifying Life Event	A qualifying life event is a significant change in your life that allows you to make changes to your benefits outside of open enrollment. See the next page for more information.

Changing Your Benefits

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

Any change you make must be consistent with the change in status. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

You must submit your change within 30 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

Enrolling for Benefits

Log In Instructions

To log into BenXcel, go to: <https://benxcel.net>

- Enter your user name: The first 4 letters of your last name and last 4 digits of SSN. (Ex: Mickey Mouse SSN: 123456789 would be- mous5678)
- Enter your initial password: The first 4 letters of your last name and first 4 digits of SSN (ex: mous1234)
- Enter the Company Name: SBMWD
- Click the Sign In button to enter the system

Enrollment Process

- Required Employee Usage Agreement, Legal Agreement, and an Open Enrollment Welcome screen will appear. Review the messages and click the Continue button to proceed.
- 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
- A Demographics page will appear for you to review your existing information.
 - Click the Save button to proceed.
- 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.
- Your enrollment will now begin. You will be walked through a series of benefit screens, presenting only the benefits available to you.



Don't miss your enrollment deadline on October 17th, 2026!

Enrolling for Benefits

Enrollment Process (Cont.)

- 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.
- Click the “Enroll Now” button to choose a Plan. The next benefit available will automatically appear.
- 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.
- A Confirmation Statement will appear when the enrollment is complete. This Statement will show your demographic information, current enrollment summary (2025) benefit elections, and all future enrollment summary (2026) 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.
- **Click the “Finish” button to save and submit the 2026 Benefit Elections.**
- A pop up will appear that your enrollment is complete and then your dashboard will appear.
- 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.
- Once satisfied with your elections, log out of BenXcel by clicking your Name then “Log Out” at the top right corner of your screen.





Medical

Our medical plans offer comprehensive coverage. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose.

Medical Plan Overview

This guide serves as a summary of the medical plans. Please review the plan documents before selecting a plan.

	What you need to know
Kaiser HMO (PRISM) <i>Kaiser Network</i>	• Access to Kaiser providers/facilities exclusively • Requires PCP to see specialist • No deductible • Predictable costs
Anthem (PRISM) Premier HMO <i>California Care</i>	• In-network only • Requires PCP to see specialist • No deductible • Predictable costs
Anthem (PRISM) PPO Classic	• Must meet deductible for some services before the plan begins to pay a % of the cost • Out-of-network coverage; higher costs

Medical HMO Comparison

	Kaiser (PRISM) HMO	Anthem (PRISM) Premier HMO
Accumulation Period	Calendar year from January 1 to December 31	Calendar year from January 1 to December 31
Calendar Year Deductible Individual Coverage Family Coverage	None None	None None
Calendar Year Out-of-Pocket Maximum Individual Coverage Family Coverage	\$1500 \$3000	\$1500 \$3000
Office Visit Primary Care Specialist	\$20 \$20	\$20 \$20
Preventive Services	Plan pays 100%	Plan pays 100%
Urgent Care	\$20	\$20
Emergency Room	\$50 (copay waived if admitted)	\$50 (copay waived if admitted)
Lab and Imaging Basic/Complex	Plan pays 100%	Plan pays 100%
Outpatient Surgery/Services	\$20 copay per procedure	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%
Chiropractic (up to 20 visits/year)	\$15 copay	\$20 copay
PRESCRIPTION DRUGS		
Calendar Year Deductible	None	None
Calendar Year Out-of-Pocket Maximum	Combined with medical	Combined with medical
Retail- 30 Day Supply Generic Preferred Brand Non-Preferred Brand	\$10 copay \$30 copay \$30 copay	\$10 copay \$30 copay \$45 copay
Mail Order- 100 Day Supply Generic Preferred Brand Non-Preferred Brand	\$20 copay \$60 copay \$60 copay	\$20 copay \$60 copay \$90 copay

Medical PPO

	Anthem (PRISM) Classic PPO	
	In-Network	Out-of-Network
Accumulation Period	Calendar year from January 1 to December 31	
Calendar Year Deductible¹ Individual Coverage Family Coverage	\$500 \$1000	\$500 per individual (combined with in-network) \$1000 family limit (combined with in-network)
Calendar Year Out-of-Pocket Maximum Individual Coverage Family Coverage	\$2000 \$4000	\$2000 per individual (combined with in-network) \$4000 family limit (combined with in-network)
Office Visit Primary Care Specialist	\$20 \$20	Plan pays 60% after deductible Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Urgent Care	\$20 copay	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) ²
Lab and Imaging Basic/Complex	Plan pays 90% after deductible	Plan pays 60% after deductible (complex imaging: up to \$800 per test; all other: up to \$350 per day)
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 60% after deductible (up to \$350 per day)
Inpatient Hospitalization	Plan pays 90% after deductible	\$250 admission copay then plan pays 60% after deductible (up to \$600 per day)
Chiropractic (up to 30 visits/year)	\$20	Plan pays 60% after deductible (in network limitations apply)
PRESCRIPTION DRUGS		
Calendar Year Deductible³	None	None
Calendar Year Out-of-Pocket Maximum	\$5,350 per individual/\$10,700 per family	Non-Network claims do not apply to the Out-of-Pocket limit
Retail- 30 Day Supply Tier 1 Tier 2 ¹ Tier 3 ¹	\$10 \$20 \$35	\$10 \$20 \$35
Mail Order- 90 Day Supply Tier 1 Tier 2 ¹ Tier 3 ¹	\$15 \$30 \$50	Not covered Not covered Not covered

¹ Deductible waived. Deductible does not apply to In-Network providers.

² \$500 additional copay if you do not receive pre-authorization for non-emergency services at an Out-of-Network provider.

³ 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.

Kaiser Resources

One Pass Select Affinity by Optum

Through One Pass Select Affinity from Optum members can choose a fitness plan and get unlimited access to all locations available within that plan, plus extensive digital resources. Members can choose the plan that fits their needs, with competitive plans starting at \$10 per month. Members that sign up can also access the Optum Additional service include healthy meal delivery and 20% discounts on chiropractors, acupuncturists and massage therapists. Learn more at kp.org/exercise.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (833) 574-2273.

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Kaiser's travel [website](#) will explain what to do if you need emergency or urgent care during your trip.

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.

Finding a Kaiser Provider

To find a Kaiser Permanente provider near you, please visit www.kp.org or call (800) 464-4000.

My Health Manager

Stay engaged with your health and simplify your busy life by using the [Kaiser Website](#) or download the Kaiser Permanente app from the App StoreSM or Google Play[®].

Headspace Care App

The Headspace Care app offers immediate 1-on-1 support for coping with many common challenges — from stress and low mood to issues with work and relationships, and more. Headspace Care's highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Download the app from the App StoreSM or Google Play[®].

Target Retail Clinics

Target Clinics offer care provided by Kaiser Permanente for more than 85 different services, including treatments for common health conditions and minor injuries. The clinics are open 7 days a week for appointments and walk in care. Find a clinic near you using kptargetclinic.org.

Online wellness tools

Visit kp.org/healthyliving for wellness information, health calculators, fitness videos, podcasts, and recipes from world class chefs. Connect to better health with programs to help you lose weight, quit smoking, and more – all at no cost.



PRISM Anthem Resources

Sydney Mobile App

Use Sydney™ Health to keep track of your health and benefits- all in one place. Access your plan details, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

Building Healthy Families

Building Healthy Families offers personalized, digital support through the SydneySM Health mobile app or on anthem.com/ca. This all-in-one program, at no extra cost to you, can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

Lark Diabetes Management Program

Available to participants of HMO plans at no cost. Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time.

Virtual Primary Care

Through Anthem's LiveHealth Online Virtual Primary Care (LHO VPC), members can choose from board-certified, in-network PCPs, and have that same doctor take care of them overtime for treatments including chronic conditions, preventative care, and acute care, at no extra cost to the member. Copay will still apply.

24/7 Nurse Line

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. For help, call the number on the back of your ID card.

Anthem ID Cards

For PPO and HDHP plans, one ID card will be issued to subscriber and one to spouse/DP. Two cards will be issued in the subscriber's name for subscriber plus child(ren) contracts. ID cards with child dependent names can be requested by calling the member service number on the ID card. For HMO plans, ID cards will be issued to each member enrolled. PPO/EPO enrollees will also receive an Navitus ID card to access pharmacy benefits.

Provider Finder

To find a provider in your plan network, please visit anthem.com/ca/prism/home.

NEW! Digbi Health - Diabetes, Obesity & GI Care



Your Digbi Health Journey

The Digbi Health program is a personalized 52-week journey designed to transform your health and wellness. Whether you're managing your weight, Type 2 Diabetes, digestive health, or taking GLP-1s for weight management, Digbi is here to support you with care tailored to your biology. Digbi Health is available at no cost for eligible members covered by Anthem through your employer.

This program includes:

- Gut & Gene Testing Kits
- Glucose Monitoring Device
- Tailored Meals
- Health Coach
- GLP-1s for weight management

Contact Digbi at prism@digbihealth.com or at (866) 344-2189 if you have any questions.

GLP-1 Eligibility

Eligibility requirements for accessing GLP-1s for weight management:

- 18 years or older and enrolled in Anthem (Mandatory).
- BMI 40 or higher without any comorbidity (OR)
- BMI 35 - 39 with at least one related comorbidity (OR)
- Mandatory: If you're on a GLP-1 for weight management, you should have lost 5% weight within 90 days of starting them.
- Digbi to be the sole prescriber for all weight loss medications.

Get Started

1. Check your eligibility and sign up for the program at digbihealth.com/prism.
2. If you are eligible, download mobile app - onelink.to/digbi.
3. On the app, please confirm shipping address and answer onboarding questions - your kits will be ordered to your address, automatically.
4. Starting January 1, 2026, you will have 90 days to go through Digbi Health's Reauthorization for weight management GLP-1 medication based on the new eligibility criteria.

Digbi Health App

- **Get at-home Test Kits** - Within a week, you'll receive a comprehensive testing kit including a Genetic Test, a Gut Microbiome Test, and an Abbott Libre Continuous Glucose Monitor. Please follow instructions to collect samples and return kits using pre-labeled shipping.
- **Sync your Health Apps** - Connect Apple or Google Health Apps with the Digbi App. Navigate to settings, choose "Health", then connect by tapping "Refresh" under "Apple Health".
- **Say hi to your Coach!** - Tap the 'Coach' button at the bottom to start engaging with your health coach on the app and upload meal pictures for scoring while you await test results.

NEW! Prescription Drugs – Navitus

Filling Your Prescriptions

Anthem members have access to prescription drug coverage through Navitus.

- **Network Pharmacy** – Most independent and all major chain pharmacies, are part of your benefit network.
- **Costco Mail Order** – A 90-day supply of maintenance medications can be mailed right to your door. You don't need to be a Costco member to use their pharmacies. Just register online at pharmacy.costco.com or call (800) 607-6861 to get started.
- **Specialty Pharmacy** - Lumicera Health Services, our specialty pharmacy partner, provides a high level of personalized care for members with complex conditions. Their clinical team will help you manage side effects and reduce complications, so you can focus on the things that matter most. Visit lumicera.com/patients/ or call (855) 847-3553 for more information.

Member Portal & App

Go to navitus.com/members to access the member portal or download the Navitus mobile app. Register for your account, if you haven't already done so. Log into the Navitus member portal and app with the same username and password. Once registered, click Sign In, then enter your login details and password. From here you can:

- View or print your member ID card
- Perform a Drug Search for coverage details
- Find drug prices and pharmacy locations
- Easily track your medication history

***Please note that all members will be getting a replacement Pharmacy Card!**

Simplifying Prior Authorization, Step Therapy & Exception to Coverage

There are certain conditions and medications which require extra steps to gain approval to fill the prescription, but Navitus tries to make it as easy as possible.

- **Prior Authorization (PA)** – Some prescriptions require prior authorization to be filled, which your health care provider will need to help facilitate. Drugs that need prior authorization are listed on your formulary with a PA. Most prior authorization requests are reviewed within two business days and urgent requests within one business day.
- **Step Therapy** – When there's an effective alternative available that's less expensive for you, you may be asked to try that before a more expensive prescription is authorized.
- **Exception to Coverage (ETC)** – If a drug isn't approved, you and your doctor can submit an ETC request showing alternative medications aren't effective or suitable for your personal situation.
- **Coverage Details** - If there are any limits or requirements on your medications like the ones listed above, a Coverage Details button will appear on the medicine's description page in the portal. Clicking on that button will outline what's needed to get the prescription filled.

Navitus Customer Care

Carrier ID: NVPSM

Phone: 855-847-1035

Website: <https://benefitplans.navitus.com/NVPSM>

Available 24 hours a day, 7 days a week; Closed Thanksgiving & Christmas

PRISM Value Added Services

Take advantage of these value added services available to PRISM plan members to help you get and stay healthy.

Benefit Highlights

Physical Therapy for Back or Joint Pain Hinge Health

Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy. Available for preventative, acute, and chronic needs at no cost.

Hip, Knee, and Spine Surgical Benefit and Breast Cancer Treatment Benefit

Carrum Health

Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel for patient and companion, and medical bills. Oncology benefit also available; guidance for all cancers; treatment for Breast Cancers.

Free Generic Maintenance Medications Rx 'N Go

As part of your benefits, you have the option to receive up to a 90-day supply of generic maintenance medication by mail at no cost to you (\$0 copay, \$0 shipping) through a convenient program called, Rx 'n Go.

Discount Medications

GoodRx

Discounts on medications for non-benefit eligible employees. GoodRx allows you to simply and easily search for retail pharmacies that offer the lowest price for specific medications.

Availability & How To Get Started

*PPO and non-Kaiser HMO
Members*

Call: (855) 902-2777

Visit

hingehealth.com/prism/



PPO Members

Visit carrumhealth.com



*PPO, non-Kaiser HMO
Members*

Call: (888) 697-9646

Visit: rxngo.com



*All non-benefit eligible
employees*

Members Call:

(888) 799-2553

Pharmacies Call:

(844) 857-4351

Visit gold.goodrx.com





Dental

We offer dental coverage through Delta Dental. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental Plan Overview

This guide serves as a summary of the dental plans. Please review the plan documents before selecting a plan.

	What you need to know
Delta Dental PPO (Core and Buy Up) <i>Narrow Network</i>	• Must meet deductible for some services before the plan begins to pay a % of the cost • Out-of-network coverage; higher costs
DeltaCare HMO <i>Narrow Network</i>	• In-network only • Requires primary care dentist • No deductible • Predictable costs

Dental insurance covers multiple types of treatment:

1. **Preventive** care includes exams, cleanings and x-rays
2. **Basic** care focuses on repair and restoration with services such as fillings, root canals, periodontics.
3. **Major** care goes further than basic and includes bridges, crowns and dentures
4. **Orthodontia** treatment to properly align teeth within the mouth.

Delta Dental (PRISM) DPPO Plans

	DELTA DENTAL CORE PLAN		DELTA DENTAL BUY-UP PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$50	\$50	\$50	\$50
Annual Plan Maximum	\$1000	\$1000	\$1500	\$1500
Diagnostic & Preventative Exams Cleanings X-rays	Plan pays 100%	Plan pays 80%	Plan pays 100%	Plan pays 80%
Basic Services Fillings Root Canals Periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services Crowns Bridges Implants	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontia Adults	80% up to \$2000 lifetime maximum	80% up to \$2000 lifetime maximum	80% up to \$2000 lifetime maximum	80% up to \$2000 lifetime maximum
Children	Covered	Covered	Covered	Covered

Delta Dental Perks



- **Virtual dentistry** – Get remote video or photo consultations with a dentist at low or no cost.
- **Amplifon Discount** - members get an average savings of 62% off the latest retail hearing aid price.
- **QualSight Discount** - members get an average savings of 62% off the latest retail hearing aid price.

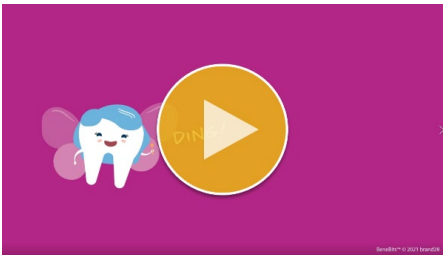
Visit www1.deltadentalins.com/memberperks.html to access all of these perks and more!

Delta Dental (PRISM) DHMO

	In-Network Only
Network Name	DeltaCare
Annual Deductible	None
Annual Plan Maximum	Unlimited
Diagnostic & Preventive Exams Cleanings X-rays	\$0-\$45 Copay
Basic Services Fillings Root Canals Periodontics	\$0-\$110 \$0-\$280 \$0-\$280
Major Services Crowns Bridges Implants	\$25-\$240
Orthodontia Adults	\$1900
Children (up to age 19)	\$1700

All About Dental

Watch this video to brush up on the ins-and-outs of dental insurance.



Click to play video

Delta Dental Perks

What you need to know about this plan

Do I have to select a primary dentist?	Yes
Can I use my FSA?	If you participate in a healthcare FSA, you can use your account to pay for dental expenses.
Where can I get more details?	Visit www.deltadentalins.com for more information and additional resources.



Vision

We offer vision coverage through EyeMed Vision. Vision coverage helps with the cost of eyeglasses or contacts.

Vision Plan Overview

This guide serves as a summary of the vision plan. Please review the plan documents before selecting a plan.

	What you need to know
EyeMed Vision	• Out-of-network coverage will have higher costs • The plan will reimburse up to a specific dollar amount for most materials



[Click to play video](#)

All About Vision

Watch this video to learn more about what to keep an eye out for when it comes to vision insurance.

EyeMed Vision

	EyeMed Vision	
	In-Network	Out-of-Network Reimbursement
Exams <i>Once every 12 months</i>	\$10 copay	Up to \$49 Allowance
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens <i>Once every 12 months</i>	\$10 copay \$10 copay \$10 copay	Up to \$35 Allowance Up to \$49 Allowance Up to \$74 Allowance In-network limitations apply
Frames <i>Once every 12 months</i>	Up to \$130 Allowance + 20% Off retail Price over \$130	Up to \$60 Allowance In-network limitations apply
Contacts (Elective)¹ <i>Once every 12 months</i>	Up to \$130 Allowance +15% Off Retail Price Over \$130 (conventional lenses)	Up to \$104 Allowance In-network limitations apply

¹In lieu of glasses.

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.

What you need to know about this plan

What other services are covered?	The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.
Eyeglasses are expensive. Will I still be able to afford them, even with insurance?	Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.
Where can I get more details?	Download the EyeMed Members app.



Life & Disability

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income.

Is your family protected?

Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children’s education, student loans, consumer debt, etc.) after the death of a spouse or partner.

	Who is covered
Life and AD&D <i>Employer Paid</i>	• Employee • Dependent
Life and AD&D <i>Voluntary Employee Paid</i>	• Employee • Spouse • Child
Short Term Disability (STD) <i>Employer Paid</i>	• Employee only
Long Term Disability (LTD) <i>Employer Paid</i>	• Employee only
Maternity & Parental Leave <i>Employer Paid</i>	• Employee only

Your Beneficiary = Who Gets Paid

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Company Provided Life and AD&D Insurance

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
Confidential	\$50,000	\$50,000	\$1,000
Executive	\$50,000	\$50,000	\$1,000
Board Members	\$50,000	\$50,000	\$1,000

Additional Features

- **Waiver of Premium** - If you become totally disabled while insured under this plan and under age 60, and complete a waiting period of 180 days, your Basic and Additional Life insurance may continue without premium payment until age 65 provided you give Voya satisfactory proof that you remain totally disabled.
- **Accelerated Death Benefit** - If you become terminally ill, you may be eligible to receive up to 80% of your combined Basic and Supplemental Life benefit to a maximum of \$50,000.
- **Portability** - If your insurance ends because your employment terminates, you may continue to your life insurance coverage by obtaining the cost directly from Voya.
- **Conversion** - If your insurance ends or reduces, you may be eligible to convert your life insurance to an individual life insurance policy without submitting proof of good health. Premiums for the converted policy will be substantially higher compared to the San Bernadino Municipal Water Department sponsored term plan.

Voluntary Life and AD&D Insurance

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.

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (after the date you become eligible), you must complete and submit EOI.



Disability Insurance

Short-Term Disability Insurance (STD)

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. San Bernadino Municipal Water Department pays the cost of this coverage. Coverage is provided by Voya Financial.

Long-Term Disability Insurance (LTD)

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. . San Bernadino Municipal Water Department pays the cost of this coverage. Coverage is provided by Voya Financial.

Parento -- Maternal & Paternal Leave

Parento's paid maternal and paternal leave program offers unlimited emotional and parenting support with 1-on-1 coaching. Parento works alongside your STD program where appropriate. Dedicated leave managers guide employees through STD. Parent coaching proactively engages parents to offer career, emotional, and parental support – **regardless of parenting stage**.

Resources include:

- [Parental leave allotment of 12 weeks at 66.67% of pay up to \\$2,000](#)
- Emotional support + practical parenting advice
- Support for well-being, communication, and logistical needs
- Psychological and emotional support, e.g parent guilt
- Access for employees' partners and current parents, included
- Practical guidance for transitioning to and from leave

Visit www.parentoleave.com/coaches to learn more and request coaching. To access coaching include the parental Coaching Code with your request: 526-88-583

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



Voluntary Plan

Pet Insurance

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. Membership is effective for 1 year from the effective date of the coverage unless you no longer own the pet, or the pet has passed.



Financial Wellness

We offer benefits and resources to help you make the most of your money now and in the future.

Why Does Financial Wellness Matter?

Financial wellness directly impacts various aspects of your life, including physical and mental health, relationships, and career satisfaction. A strong financial footing reduces stress and anxiety related to money, leading to better mental health and overall quality of life. It enables you to pursue your goals, whether it's buying a home, starting a family, or planning for retirement, without the constant burden of financial worry.

	What you need to know
Healthcare Flexible Spending Account (FSA)	Use tax-free dollars for healthcare related expenses.
Dependent Care Flexible Spending Account (FSA)	Use tax-free dollars for childcare expenses.



Click to play video

Benefits © 2022 SunLife

All About FSA

Watch this video to learn all about the ins-and-outs of FSA.

Flexible Spending Account (FSA)



IMPORTANT: You must re-enroll in this account each year. Elections do not rollover.

A Healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses. This program is administered through BCC.

Types of FSA offered:

Healthcare 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 \$3,300 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). 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.

Are You Eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Do You Pay For Dependent Care?

You will obtain tax savings if you enroll in the Dependent Care FSA.

2026 IRS Contribution Limits

You can contribute up to \$3,300 for Healthcare FSA or up to \$7,500 for Dependent Care FSA (or \$3,750 if you're married and file separate tax returns).

Contributions are deducted from your pay pre-tax.

Deadline To Incur Claims

Expenses must be incurred between 1/1/2026 and 03/31/2027 for the Dependent Care FSA and 01/01/2026 to 03/15/2027 for the Healthcare FSA.

Deadline To Submit Claims

Claims must be submitted for reimbursement no later than 03/31/2027 for the Healthcare FSA.



Wellbeing & Balance

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

A Happier, Healthier You

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

	What you need to know
Employee Assistance Program (EAP)	Access resources to manage stress, chemical dependency, mental health and family issues.
Mental Health Resources	Mental health coverage provided by your medical carrier. Please refer to page 9 for your medical coverage details.
Wellness Program	Maximize your physical well-being

Important

For immediate assistance in a mental health crisis please call 911. Or call the National Suicide Prevention Lifeline at 988 for a national network of local crisis centers that provides free and confidential emotional support.

Employee Assistance Program (EAP)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through AnthemEAP can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or online visits; up to 6 visits per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools

Available Resources

Counseling Benefits

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

Parenting & Childcare

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

Financial Coaching

- Money management
- Debt management
- Identity theft resolution
- Tax issues

Legal Consultation

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Eldercare Resources

- Help with finding appropriate resources to care for an elderly or disabled relative

Online Resources

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

Contact the EAP

Phone

833-954-1067

Website

anthemEAP.com (enter code PRISM)





Important Plan Information

In this section, you'll find important plan information, including:

	What you need to know
Your Benefit Costs	An overview of your healthcare costs.
Important Contacts	Contact information for our benefit carriers and vendors.
Important Notices	A summary of the health plan notices you are entitled to receive annually, and where to find them.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. San Bernadino Municipal Water Department if your domestic partner is your tax dependent.

Your Benefit Costs

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

Medical	Anthem HMO	Anthem PPO	Kaiser HMO
Employee Only	\$906.50	\$1,269.50	\$807.50
Employee + 1	\$1,801.50	\$2,520.50	\$1,605.50
Employee + Family	\$2,417.50	\$3,384.50	\$2,154.50

Dental	Delta HMO	Delta PPO	Delta PPO Buy Up Plan
Employee Only	\$16.80	\$32.90	\$38.20
Employee + 1	\$29.90	\$70.90	\$82.70
Employee + Family	\$43.80	\$96.80	\$113.00

Vision	EyeMed
Employee Only	\$6.13
Employee + 1	\$11.58
Employee + Family	\$16.96

Department Contributions

Monthly Department Contributions	
Employee Only	\$958.00
Employee + 1	\$1,762.00
Employee + Family	\$2,270.00

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

Plan Contacts

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

Plan Type	Provider	Phone Number	Website/Email	Policy No.
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	Navitus	855-847-1035	https://benefitplans.navitus.com/NVPSM	N/A
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
Parento	Maternal & Paternal Leave	N/A	www.parentoleave.com/coaches Coaching Code: 526-88-583	N/A
Employee Assistance Program (EAP)	Anthem EAP	800-676-BLUE (2583)	www.anthem.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 hr@sbmwd.org	N/A
Deferred Compensation Section 457 Plan	Empower	800-743-5274	www.retiresmart.com	63122

Important Plan Information

Health Plan Notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **ACA Disclaimer:** This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2026 of your modified adjusted household income.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA Continuation Coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

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 This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further. 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.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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](https://www.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, 2026
Name of Entity/Sender:	San Bernadino Municipal Water Department
Contact-Position/Office:	Human Resources
Address:	1350 S. E Street, Building B, San Bernadino, CA 92408
Phone Number:	(909) 453-6091

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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 will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. You can contact your health plan's Member Services for more information.

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 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

If you decline enrollment in through Public Risk Innovation, Solutions, and Management (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 through Public Risk Innovation, Solutions, and Management (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 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 your request for enrollment. In addition, you may enroll in Public Risk Innovation, Solutions, and Management (PRISM)'s health 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 a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Notice of Choice of Providers

The Anthem and Kaiser HMO plans generally require 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. Until you make this designation, Anthem and Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Anthem or Kaiser customer service.

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

You do not need prior authorization from Anthem or Kaiser 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 the Anthem or Kaiser customer service.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 (9.02% in 2025) of your modified adjusted household income.

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 **July 31, 2025**. Contact your State for more information on eligibility—

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: 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

Determining Eligibility

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 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 PART-TIME, VARIABLE HOUR OR SEASONAL SCHEDULE: If you are hired into a part-time position, a position where your hours vary and San Bernadino Municipal Water Department is unable to determine — as of your date of hire — whether you will be a full-time employee, 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 day of the month following your date of hire and will last for 12 months. If, during your IMP, you average 130 or more hours a month, you will become 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 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 Bernadino 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 during which San Bernadino Municipal Water Department counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed 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 during an associated stability period for a 12 month 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 Bernadino Municipal Water Department uses the standard measurement period and associated stability period annual cycle set forth below:

MEASUREMENT PERIOD: November 1- October 31

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.

STABILITY PERIOD: January 1- December 31

Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.



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