



2026

COBRA Benefits Overview

Making Benefits Work For You



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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.

Getting Started

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

OPEN ENROLLMENT

October 6th – October 17th, 2025

All enrollments must be completed with Benefit Coordinators Corporation (BCC) by October 17, 2025 at 3:00pm PST.

If you have questions or making changes, contact BCC Customer Service at 855.230.0745 x 6414.

IMPORTANT NOTE:

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

A pre-recorded presentation providing a broad explanation of 2026 benefits is available by clicking the link below:

<https://www.brainshark.com/alliant/2026sbmwdoe>



As a Cobra participant, you have the opportunity to make changes to your current benefit plans during this annual Open Enrollment period. Open Enrollment is your once-a-year opportunity to elect, change or cancel your benefit coverage or add/drop dependent coverage.

Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), if you have filed with the state of California.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26. They are not required to live with you or be enrolled in school. They can be married and/or living and working on their own.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

Birth and marriage document are required for enrollment.



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.

What's New?

What's New?

Introducing Navitus Pharmacy Benefits - Navitus is replacing Express Scripts (ESI) for prescription drugs benefits beginning 01/01/2026. See page 12 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 11 for more information.



Changing Your Benefits



Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

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).
- Purchasing marketplace coverage

You must submit your change within 30 days after the event. Please contact BCC immediately following a qualifying event to complete the appropriate election forms. If you do not update your coverage within 30 days of the qualifying event, you will need to wait until the next annual open enrollment period to make any changes.

Dependent Eligibility Requirements

Coverage	Requirements
New Dependent	Marriage and birth certificates are required to add dependents.



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

We offer 1 medical plan through Kaiser, and 2 medical plans through Anthem.

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



[Click to play video](#)

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	\$10 copay, 20 visits/year	\$15 copay, 60 visits/year
PRESCRIPTION DRUGS		
Calendar Year Deductible	None	None
Calendar Year Out-of-Pocket Maximum	Combined with medical	Combined with medical
Retail Generic Preferred Brand Non-Preferred Brand	\$10 copay \$30 copay \$30 copay	\$10 copay \$30 copay \$45 copay
Supply Limit	30 day supply	30 day supply
Mail Order Generic Preferred Brand Non-Preferred Brand	\$20 copay \$60 copay \$60 copay	\$20 copay \$60 copay \$90 copay
Supply Limit	100 day supply	90 day supply

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 ¹ \$20 ¹	Plan pays 60% after deductible Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Urgent Care	\$20 ¹ copay	Plan pays 60% after deductible
Emergency Room²	\$50 copay then plan pays 90% after deductible (copay waived if admitted)	\$50 copay then plan pays 90% after deductible (copay waived if admitted)
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% ² after deductible (up to \$600 per day)
Chiropractic (up to 30 visits/year)	\$20 ¹	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 ³ Tier 3	\$10 \$20 \$35	\$10 \$20 \$35
Mail Order- 90 Day Supply Tier 1 Tier 2 ³ Tier 3 ³	\$15 \$30 \$50	Not covered Not covered Not covered

¹ Deductible waived.

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](tel: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, and gum disease treatment
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.

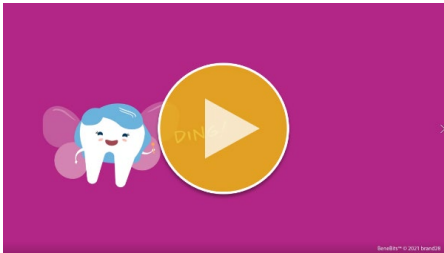
Visit www1.deltadentalins.com/memberperks.html to access all of these perks and more!

Delta Dental (PRISM) DHMO

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



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. Notify CLIENT NAME 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

PLEASE NOTE THE ABOVE OPTION COSTS DO NOT CONTAIN THE 2% COBRA ADMINISTRATION FEE.

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	866-723-0513	www.eyemedvisioncare.com	9928466
COBRA Administration	Benefits Coordinators Corporation	855-230-0745 Ext. 6414	https://benxcel.net	N/A
Enrollment & Call Center for COBRA Participants	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
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **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.
- **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.

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

