2026

Early Retiree Benefits Overview

Making Benefits Work For You

CITY OF SAN BERNARDINO WATER DEPT.

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What's New or Changing?

Introducing Navitus Pharmacy Benefits–
Navitus is replacing Express Scripts (ESI) for prescription drugs benefits beginning 01/01/2026. See page 13 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 12 for more information.

A pre-recorded presentation providing a broad explanation of 2026 benefits is available by clicking the link below:
https://www.brainshark.com/1/player/alliant?custom=sbmwd2026oe

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

OPEN ENROLLMENT

October 6 – October 17, 2025

2026 BENEFITS

January 1, 2026 through
December 31, 2026

Dear valued San Bernardino Municipal Water Department retiree:

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

Open Enrollment is your once-a-year opportunity to elect, change or cancel your benefit coverage or add/drop dependent coverage.

This guide provides an overview of your healthcare coverage, retirement benefits, 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.

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

October 6 – October 17, 2025

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.**

2026 Offerings:

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

Retiree Billing

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

All enrollment and/or changes must be completed by contacting BCC Customer Service at (855) 230-0745 Ext. 6414 prior to October 17th at 3:00pm (PST). No action is required if you are not making any changes to your current medical plan.

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

Who is Eligible?

Retirees

After your initial enrollment, unless you qualify for a "special enrollment", you cannot change your elections until the next annual "Open Enrollment". You are allowed to terminate your coverage at anytime during the year by submitting a written request to SBMWD; however, once you have submitted this request there will be no reinstatement.

The following dependents are eligible for benefits:

- Legally married spouse.
- Registered Domestic Partner (RDP), if you have filed with the sate 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).

For additional information, please refer to the plan documents for each benefit.

Who is not eligible?
Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.

Documentation
Birth and marriage documents are required when enrolling, along with Social Security Number.

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

Changing Your Benefits

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

Qualified Status Changes include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by your spouse, or your dependent child
- **Change in work schedule**, including an increase or decrease in hours of employment by your spouse, or your dependent child; or a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite**, including a change that affects the accessibility of network providers
- **Change in your health coverage or your spouse's coverage**, attributable to your spouse's employment
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA),** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **You will not be able to re-enroll in a retirement plan if your coverage is canceled.**

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

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

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

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

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

Medical HMO Plan

This table shows member cost share.

	Kaiser (PRISM) HMO (Early Retirees)	Anthem (PRISM) Premier HMO (Early Retirees)
	In-Network	**In-Network**
Annual Deductible	None	None
Annual Out-of-Pocket Maximum[2,3] Individual Coverage Family Coverage	$1,500 per individual $3,000 family limit	$1,500 per individual $3,000 family limit
Lifetime Max	Unlimited	Unlimited
Office Visit Primary Care/Specialist	$20 copay	$20 copay
Preventive Services	Plan pays 100%	Plan pays 100%
Urgent Care	$20 copay	$20 copay
Emergency Room	$50 copay (copay waived if admitted)	$50 copay (copay waived if admitted)
Lab and X-ray	Plan pays 100%	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%
Outpatient Surgery	$20 copay	Plan pays 100%
Chiropractic Care	$15 copay (up to 20 visits per calendar year)	$20 copay (60 day limit per benefit period for Physical, Occupational and Speech Therapy combined)
PRESCRIPTION DRUGS		
Prescription Drug Deductible	None	None
Annual Out-of-Pocket Maximum	Combined with medical	Combined with medical
Pharmacy Generic Preferred Brand Non-Preferred Brand Supply Limit	 $10 copay $30 copay $30 copay 30 days	 $10 copay $30 copay $45 copay 30 days
Mail Order Generic Preferred Brand Non-Preferred Brand Supply Limit	 $20 copay $60 copay $60 copay 100 days	 $20 copay $60 copay $90 copay 90 days

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

Medical PPO Plan

This table shows member cost share.

	Anthem (PRISM) Classic PPO (Early Retirees)	
	In-Network	**Out-of-Network**
Annual Deductible[1] Individual Coverage Family Coverage	$500 per individual $1,000 per family	$500 per individual (combined with in-network) $1,000 per family (combined with in-network)
Annual Out-of-Pocket Maximum[2] Individual Coverage Family Coverage	$2,000 per individual $4,000 per family	$2,000 per individual (combined with in-network) $4,000 per family (combined with in-network)
Lifetime Max	Unlimited	Unlimited
Office Visit Primary Care Specialist	$20 copay[1] $20 copay[1]	Plan pays 60% after deductible Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Urgent Care	$20 copay[1]	Plan pays 60% after deductible
Emergency Room	$50 copay then plan pays 90% after deductible (copay waived if admitted)	$50 copay then plan pays 90% after deductible (copay waived if admitted)
Lab and Imaging Basic/Complex	Plan pays 90% after deductible	Plan pays 60% after deductible (complex imaging: up to $800 per procedure; all other: up to $350 per visit)
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 Care	$20 copay[1] (up to 30 visits per year)	Plan pays 60% after deductible (in-network limitations apply)
PRESCRIPTION DRUGS		
Prescription Drug Deductible	None	None
Annual 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 Tier 1 Tier 2[3] Tier 3[3] Supply Limit	$10 copay $20 copay $35 copay 30 days	$10 copay $20 copay $35 copay 30 days
Mail Order Tier 1 Tier 2[3] Tier 3[3] Supply Limit	$15 copay $30 copay $50 copay 90 days	Not Covered Not Covered Not Covered Not Applicable

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

[2]$500 additional deductible for non-Anthem PPO hospital if utilization review not obtained.

[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.

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 Sydney℠ 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.

LiveHealth Online

Visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy. Register online and download the mobile app.

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.

Concierge Cancer Care Program

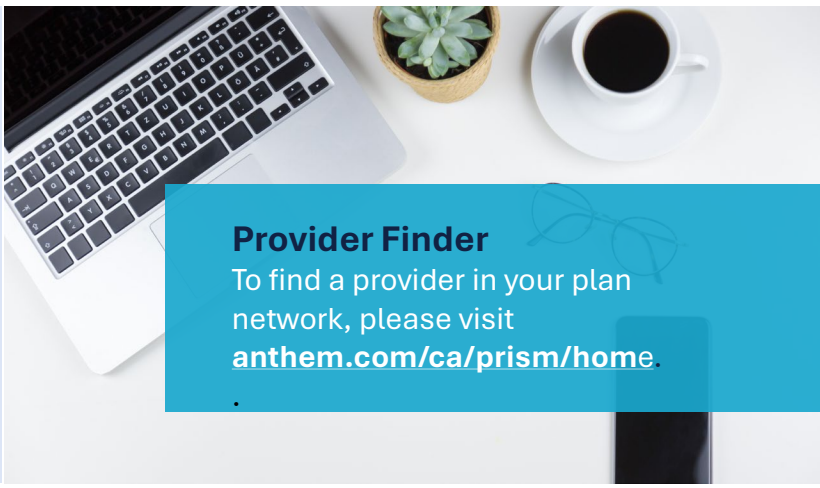
The Anthem Concierge Cancer Program provides members with 24/7 guidance, VIP-style cancer care treatment, travel benefits, best-in-class clinical trials in a concierge-style setting and service.

ConditionCare

ConditionCare is a disease management program available to members at no cost. The program provides tools, resources and support with Asthma (pediatric or adult), Chronic obstructive pulmonary disease (COPD), Coronary artery disease, Diabetes, types 1 and 2 (pediatric or adult) or Heart failure.

Anthem ID Cards

For PPO, 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 enrollees will also receive an Express Scripts ID card to access pharmacy benefits.



Provider Finder

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

Anthem Resources, Cont.

Lark Diabetes Management

Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and 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.

Hinge Health

Hinge Health has coach-led Digital Care Pathways for chronic back and joint pain, as a replacement to surgery. With exercise therapy, behavioral health coaching, and a personalized education curriculum, Hinge Health has proven outcomes of participant pain reduction, depression and anxiety reduction, and 2 out of 3 surgeries avoided. Watch a video on HingeHeal at **hingehealth.com/learn-more .**

Catapult Virtual Check-Up

Catapult Virtual Check-Up allows you to receive a Virtual Check up home-kit that includes everything you need to collect vital information. Mail in your results with the prepaid return shipping label and you will get notified when your lab work is complete. You can schedule an appointment with a Catapult Nurse Practitioner to review your results. For questions or more information, email support@virtualcheckup.com.

Amino Guidance

Amino Guidance is a digital healthcare platform that helps members find the right providers for their specific need and at the best price. This service helps to guide members to making smarter healthcare choices, get the most out of the benefit program, and save money on healthcare along the way! Visit **amino.com** for additional information.

ABA Therapy

Coverage for Pervasive Developmental Disorder or Autism will be provided according to the terms and conditions of our plan that apply to all other medical conditions, except as stated. Treatment will be subject to the same deductibles, copays, and coinsurance that apply to services provided for other covered medical conditions. You may be required to obtain pre-service review through Anthem in order for services to be covered. Contact Anthem for details.

Regenexx

Anthem members have access to Regenexx which uses your body's natural healing agents to replace the need for up to 70% of elective orthopedic surgeries. Your stem cells and blood platelets are concentrated in an on-site orthobiologics lab and injected under image guidance into the precise area of injury.

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	Availability & How To Get Started
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.	*PPO and non-Kaiser HMO Members* **Call:** (855) 902-2777 **Visit** hingehealth.com/prism/
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.	*PPO Members* **Visit** carrumhealth.com
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.	*PPO, non-Kaiser HMO Members* **Call:** (888) 697-9646 **Visit:** rxngo.com
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.	*All non-benefit eligible employees* **Members Call:** (888) 799-2553 **Pharmacies Call:** (844) 857-4351 **Visit** gold.goodrx.com

Kaiser Resources

One Pass Select Affinity by Optum

Through One Pass Select Affinty 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.

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 Store℠ 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.

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 Store℠ or Google Play®.

Important Plan Information

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

	What you need to know
Monthly Medical Premium	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 San Bernadino Municipal Water Department (SBMWD) if your domestic partner is your tax dependent.

Monthly Medical Premiums

Rates do not include contribution amounts. Please refer to your Open Enrollment memo or contact Human Resources at (909) 453-6091 for 2026 contribution amounts and questions.

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

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
Billing & Eligibility	Benefit Coordinators Corporation (BCC)	855-230-0745 Ext. 6414	N/A	N/A
457 Deferred Compensation	Empower	800-743-5274	www.retiresmart.com	63122
San Bernardino Municipal Water Department	Human Resources	909-453-6091	www.sbmwd.org hr@sbmwd.org	N/A

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 inly coverage under our base plan exceeds 9.12% in 2026 of your modified adjusted household income.
- **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.

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**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

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

Date:	January 1, 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 providers

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

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

You do not need prior authorization from Public Risk Innovation, Solutions, and Management (PRISM) or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your plan administrator.

Notice of Certain Deadline Extensions and Summary of Material Modifications

This document provides notice of the potential expiration of the deadline relief that began on March 1, 2020 and an explanation of how that expiration will affect certain deadlines tolled under prior guidance applicable to ERISA plans. Specifically deadlines cannot be tolled for longer than one-year. Whether deadlines are tolled or resume will depend on the specific date you were required to take action or provide notice to the plan. This is a Summary of Material Modifications ("Summary") to the extent those extensions applied to ERISA benefits under the plan. You should take the time to read this Summary carefully and keep it with the Summary Plan Description ("SPD") document that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding these changes to the Plan, please contact HR.

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